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TIONAL HEALTH PROGRAM

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
EIGHTIETH CONGRESS
FIRST AND SECOND SESSIONS

ON

S. 545

A BILL TO COORDINATE THE HEALTH FUNCTIONS OF THE FEDERAL GOVERNMENT IN A SINGLE AGENCY; TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR THE FOLLOWING PURPOSES: TO EXPAND THE ACTIVITIES OF THE PUBLIC HEALTH SERVICE; TO PROMOTE AND ENCOURAGE MEDICAL AND DENTAL RESEARCH IN THE NATIONAL INSTITUTE OF HEALTH AND THROUGH GRANTS-IN-AID TO THE STATES; TO CONSTRUCT IN THE NATIONAL INSTITUTE OF HEALTH A DENTAL RESEARCH INSTITUTE; AND FOR OTHER PURPOSES

AND

S. 1320

A BILL TO PROVIDE A NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH PROGRAM

PART 4

JULY 23, 1947, JANUARY 27 AND 29, 1948

Printed for the use of the Committee on Labor and Public Welfare

Institute of
14, Maryland

NATIONAL HEALTH PROGRAM

U.S. Congress. Senate. Committee on Labor and Public Welfare.

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UNITED STATES
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WASHINGTON : 1948

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NATIONAL HEALTH PROGRAM

WEDNESDAY, JULY 23, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room, Capitol Building, Senator Forrest C. Donnell, presiding.

Present: Senators Donnell (presiding in behalf of the subcommittee chairman), Smith, Murray, and Pepper.

Senator Donnell. The committee will be in session.

Is Dr. Isidore Falk present?

STATEMENT OF ISIDORE S. FALK, DIRECTOR OF THE BUREAU OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION, WASHINGTON, D. C.

Senator Donnell. Will you please state your name?

Mr. Falk. Yes, Mr. Chairman, Isidore Sydney Falk.

Senator Donnell. Where is your home?

Mr. Falk. My legal residence is in Stonington, in the State of Connecticut. My local residence is in Chevy Chase, Md.

Senator Donnell. Now, Dr. Falk, your name has come up right often in the hearings on S. 1606 last year, and hearing this year on S. 1320 and S. 545, and you have been quoted from time to time in respect to your interest in and work in connection with this subject of medical insurance.

In view of that, I desire to ask you quite a number of questions in regard to your experience and background, after which I would like to examine into your views with respect to a number of provisions of one of the bills, especially S. 1320.

I know of no better place to start than at first.

I will ask you where and when you were born?

Mr. Falk. Brooklyn, N. Y., September 30, 1899.

Senator Donnell. What was your educational background in Brooklyn?

Mr. Falk. I attended the public grade schools and the Boys' High School in Brooklyn.

Senator Donnell. Did you finish high-school work?

Mr. Falk. Yes, sir.

Senator Donnell. And you were graduated from high school in Brooklyn?

Mr. Falk. Yes, sir. I graduated from the Brooklyn Boys' High School in 1915.

Senator DONNELL. 1915?

Mr. FALK. Yes, sir.

Senator DONNELL. What did you then do immediately after you graduated from the Brooklyn High School?

Mr. FALK. Immediately after that I spent a few months in temporary employment in the American Museum of Natural History in New York City, in the Department of Public Health, in preparatory work for a job to which I had been appointed and which I was to take up that autumn at Yale University in New Haven, Conn.

Senator DONNELL. Did you take up the work at Yale that autumn?

Mr. FALK. Yes. I had a job in a laboratory in the Yale School of Medicine and which made it possible for me to pay my way through college.

Senator DONNELL. What was that particular laboratory?

Mr. FALK. The Laboratory of the Department of Public Health, Yale School of Medicine.

Senator DONNELL. What was the position you entered into?

Mr. FALK. I do not remember its name, but my duties were everything from janitor, bottle washer, dishwasher, and laboratory boy to technical assistant.

Senator DONNELL. You were what age at that time?

Mr. FALK. About 16 when I started.

Senator DONNELL. About 16 years of age?

Mr. FALK. Yes, sir.

Senator DONNELL. How long did you occupy that position at Yale?

Mr. FALK. That original job and successive positions—and I may say that I do not remember all the details about them—I held successively from 1915 until 1923, in the employ of the Yale School of Medicine. I think there were some minor interruptions as in the case of the period when I was in the United States Army (SATC).

Senator DONNELL. Do you recall, Dr. Falk, what salary you were to receive at Yale when you started there in 1915?

Mr. FALK. I think it was $600 a year for the academic year, if I recall correctly, Senator.

Senator DONNELL. Did you subsequently enter upon a course at Yale University yourself as a student?

Mr. FALK. Yes, I did.

Senator DONNELL. When did you enter upon that course?

Mr. FALK. I first entered as a special student, an arrangement which permitted me to take only such courses as I wished to take without reference to the regular curriculum. That was within the period 1915 to 1917.

I am not sure whether I first entered courses in the autumn of 1915 or early in 1916, but within the period 1915 to 1917 I was a special student and attended certain selected courses which I wished to attend. I was permitted to do this under the rules of the university, by permission of the dean of the Scientific School.

Senator DONNELL. Did you ultimately receive a degree at Yale?

Mr. FALK. Yes. In 1917, I matriculated in the regular way.

Senator DONNELL. In what department?

Mr. FALK. The Sheffield Scientific School, and in June 1920 I received the degree of bachelor of philosophy, magna cum laude.

Senator DONNELL. The Sheffield Scientific School is a part of the university?

Mr. FALK. Yes; it was one of the undergraduate schools.

Senator DONNELL. Your degree was bachelor of philosophy?

Mr. FALK. Yes, sir.

Senator DONNELL. Did you receive any other undergraduate degrees?

Mr. FALK. No, sir.

Senator DONNELL. Did you take a medical course?

Mr. FALK. No, sir.

Senator DONNELL. You are called doctor. That is because of the doctor of philosophy degree you hold. Is that correct?

Mr. FALK. Yes, sir. I received the degree of doctor of philosophy.

Senator DONNELL. Would you prefer to be called doctor or mister?

Mr. FALK. Senator, I am customarily called mister.

Senator DONNELL. Most of the time I have heard you referred to as doctor.

Mr. FALK. Some people do address me as doctor, Senator. I do not encourage it because some of my work is in a field that pertains to medicine and it sometimes leads to a misunderstanding that I am a doctor of medicine, which I am not.

Senator DONNELL. You have never taken a medical course and are not a doctor of medicine?

Mr. FALK. The latter is correct. The other is partially correct. I did not take any regular course in medical studies per se.

Senator DONNELL. Do you recall what the medical courses were that you did take?

Mr. FALK. Certain of them were the premedical courses which were taken by students majoring in the biological sciences, such as anatomy, histology, physiology, embryology, and a number of others, and, of course, chemistry and physics courses. I can recall that a course in pathology was the regular medical school course. I think I was excused from some of the courses that otherwise would have been required, such as bacteriology and immunology.

I can recall attending the courses in public health which were required of medical students, but I was excused from taking them formally since I was assisting in teaching them.

I attended parts of the courses in physical diagnosis, and some others in the clinical branches of medicine, autopsy work, and so on, but those were not required of me for my degree, so my attendance in them was only partial and voluntary, and by special arrangement. There are others which I hesitate to try to name because I have not thought about them for years.

Senator DONNELL. I understood you to say you did not take the course in bacteriology. Is that right?

Mr. FALK. I did not take the medical school course or graduate course except as an auditor or visitor. I was excused from those. I do not think I was required to take any formal course in bacteriology as an undergraduate or as a graduate student.

I did attend some of the more advanced courses in bacteriology and in the related field of immunology but it is my recollection I was excused from taking the regular courses, having apparently given satisfactory evidence that my work in those fields had gone beyond that stage.

Senator DONNELL. Had you studied bacteriology at all?

Mr. FALK. Not formally.

Senator DONNELL. Or informally?

Mr. FALK. Informally, I was laboratory assistant to one of the most distinguished bacteriologists in the world and had done a great deal of work with him.

Senator DONNELL. How long?

Mr. FALK. All through that period from 1915 on. The laboratory in which I was working was one in which bacteriological work was going on all the time.

Senator DONNELL. You say, however, you did not take a formal course in bacteriology in your undergraduate work. That is correct?

Mr. FALK. That is correct, Senator.

Senator DONNELL. I understood you to say you were excused from taking bacteriology.

Mr. FALK. I think I said I was excused.

Senator DONNELL. You were not in the medical school at all?

Mr. FALK. No, sir; not as a medical student.

Senator DONNELL. Were you ever in the Sheffield Scientific Department?

Mr. FALK. As a graduate student I was a student in the graduate school of Yale University, which required its students to take the course necessary for the graduate degrees in different——

Senator DONNELL. Confining ourselves to undergraduate work, Mr. Falk, I understood that you did not actually enter the Medical School at all in Yale University. That is correct, as an undergraduate?

Mr. FALK. If I understood your question it was, Did I matriculate as a student in the medical school? and the answer is "No."

Senator DONNELL. The answer is "No."

Mr. FALK. That is correct.

Senator DONNELL. You took your degree as bachelor of philosophy in 1920.

Can you tell us what was your major study, and so denominated in the record of the institution, if you know, leading up to the degree of bachelor of philosophy?

Mr. FALK. I am not sure. It might have been biological or premedical.

Senator MURRAY. Can you get that information for us?

Mr. FALK. Yes.

Senator DONNELL. Yes. Would you be kind enough to furnish that information to the clerk of the committee, Mr. Rodgers?

Mr. FALK. Yes, sir.

Senator DONNELL. And I will ask you to furnish any details you may have overlooked this morning. You are at perfect liberty to give us all that you think has any materiality.

Mr. FALK. Senator, I am willing to give all I have, but I am not sure as to what is material.

Senator DONNELL. Whatever you consider to be material in determining what the subject matter was.

Mr. FALK. I will be glad to furnish the clerk with a list of my courses appearing on the record furnished by the university

Senator DONNELL. And the number of hours you engaged in each of those courses, if you have that information.

Mr. FALK. Yes, sir.

(Subsequently Mr. Falk submitted the following records:)

YALE UNIVERSITY,
SHEFFIELD SCIENTIFIC SCHOOL,
New Haven, Conn., March 31, 1947.

This is to certify that Mr. Isidore S. Falk attended the Sheffield Scientific School from September 1917 to June 1920. He received the degree of bachelor of philosophy in June 1920, having pursued the undergraduate course in premedical studies. He entered on credits from________________________________. He entered without conditions, having passed the following examinations required for admission:

English, second year German, third year German, elementary algebra, advanced algebra, plane geometry, solid geometry, plane trigonometry, physics.

FRESHMAN YEAR

Courses	Grade	
	First term	Second term
Drawing	B	
English	A	A+
English composition	A	A
French	C+	B
Organic chemistry	A	A
Qualitative analysis	A	
Physiology	A	
Quantitative analysis		A

SOPHOMORE YEAR [1]

As a special student:		
Freshman chemistry	3. 5	
Freshman mathematics		3. 3
Freshman physics		3. 5
Freshman physics laboratory		3. 5

JUNIOR YEAR [2]

French	80	
War issues	90	
Physiological chemistry	93	
Public health seminar	94	
French [3]		B
English composition [3]		B
Embryology [3]		A
Histology [3]		A

SENIOR YEAR

Physiological chemistry		A
Physiology of nutrition		A
Physical chemistry	A	
Genetics	A	
Public health seminar	A	A
Physical physiology	A+	
Physiological chemistry	A	
Comparative anatomy		B
Physical chemistry	A	A
Public health	A	A

---

[1] No sophomore year for class of 1920.
[2] War regime (Medical Corps).
[3] January to June 1919.

Key: A+ (exceptional) = 95–100; A (excellent) = 90–94; B (very good) = 80–89; C+ (good) = 75–79; C (fair) = 70–74; D (passable) = 60–69; F (failure, to be made up by examination) = 50–59; X (total failure) = below 50. Marking when a special student on the scale of 2.0–4.0; 2.0 being passing grade.

He is entitled to a letter of honorable dismissal.

Respectfully submitted.

LOOMIS HAVEMEYER,
Assistant Dean, Sheffield Scientific School.

YALE UNIVERSITY GRADUATE SCHOOL

SCHOLARSHIP RECORD

Name, Isidore Sydney Falk. Date, March 30, 1937. Candidate for ________ degree. Degree of Ph. D. granted June 1923. Holder of ——— (Scholarship, Fellowship).

Year	Name of course	Instructor	Attendance per week per year		Grade
			First term	Second term	
1920–21	Principles of public health	Prof. Winslow	6		Honors.
	Elements of sanitary engineering	Prof. Barney	6		Do.
	Principles of vital statistics	Prof. Dublin	2	2	Do.
	Public health seminar	Prof. Winslow	2	2	Do.
	Immunology and special bacteriology.	Prof. Smith			Auditor.
	Public health administration	Prof. Winslow		4	Honors.
	Industrial hygiene and sanitation	do	2		Do.
	Industrial physiology	Prof. Ryan		2	Incomplete.
	Colloid chemistry	Prof. Johnston		1	Honors.
1921–22	Public health seminar	Prof. Winslow	2	2	Do.
	General pathology	Prof. Winternitz	14		Passed.
1922–23	History of biology	Prof. Woodruff	1	1	No credit given.
	Advanced applied sociology	Prof. Davie	2	2	Honors.
	Applications of physical chemistry to biological chemistry.	Prof. Saxton	1	1	Passed.
	Dissertation: The influences of certain electrolytes upon the viability and the chemical and physical properties of bacteria.	Prof. Winslow			

MARGARET C. STASE, *Registrar.*

One copy of this record is furnished free to each student.
A fee of $1 will be charged for each additional copy.

Senator DONNELL. After you had received the degree of bachelor of philosophy in Yale did you still continue your work in Yale?

Mr. FALK. Yes, sir.

Senator DONNELL. In the graduate school?

Mr. FALK. Yes; my studies continued in the graduate school.

Senator DONNELL. Is the graduate school divided into several departments, or do you just matriculate into the graduate school as a larger entity embracing the various specified studies?

Mr. FALK. I am not sure of the technical fact. I presume that when we matriculated in the graduate school in those years it required a designation of the special field of study.

Senator DONNELL. How long were you in the graduate school at Yale?

Mr. FALK. Three years.

Senator DONNELL. Did you receive the degree of doctor of philosophy at the end of that 3-year period?

Mr. FALK. Yes, sir.

Senator DONNELL. On what subject did you write your thesis?

Mr. FALK. I believe my dissertation was on a bacteriological subject.

Senator DONNELL. Do you remember what the subject was?

Mr. FALK. I cannot recall it precisely, but it had to do with conditions affecting the rate of dying of bacteria and their chemical and physical properties.

Senator DONNELL. It had nothing to do with the matter of influenza?

Mr. FALK. No, sir.

Senator DONNELL. You received your degree of doctor of philosophy in what year?

Mr. FALK. 1923.

Senator DONNELL. 1923?

Mr. FALK. Yes, sir.

Senator DONNELL. What did you do then immediately after 1923?

Mr. FALK. Well, in the autumn of that year I went to the University of Chicago, having received an appointment as assistant professor of hygiene and bacteriology.

In the interim, if I may add it, Senator, I think from 1920 on I was instructor in public health in the Department of Public Health of the Yale Medical School while I was attending the graduate school and working toward my doctorate in that department.

Senator DONNELL. You taught in the field of public health at Yale for how long a period?

Mr. FALK. I had been assistant to the professor of public health in an increasing measure in the years 1915 to 1920, in very minor capacities to begin with, and in somewhat more important capacities later. If I recall the dates and other details correctly, beginning with 1920, after I received my bachelor's degree, I was appointed an instructor and began to be responsible for teaching in a more formal way. I assisted some of the older members of the faculty in some of their courses and gave some courses myself in various fields.

Senator DONNELL. You are speaking of Yale?

Mr. FALK. That is 1920 to 1923.

Senator DONNELL. When you went to Chicago University you were there for about 6 years, were you not?

Mr. FALK. Yes, sir.

Senator DONNELL. And you taught hygiene and bacteriology?

Mr. FALK. That was the name of the department.

Senator DONNELL. What did you teach?

Mr. FALK. I taught courses in bacteriology, in immunology, in vital statistics, in public health, in advanced theoretical problems in bacteriology and immunology, and I am not sure whether I gave formal courses in fields like epidemiology. I am not sure of the details at this point, but those are approximately the fields in which I taught courses during those years.

Senator DONNELL. When did you leave Chicago University?

Mr. FALK. At the end of the autumn quarter of 1929. That would be something like the end of November.

Senator DONNELL. Had you been engaged to teach throughout the year 1929 or 1930?

Mr. FALK. Through the academic year. Our formal contracts, if I recall correctly, were in terms of teaching three out of four quarters. The appointment applied to three of the four quarters. Members of the faculty were free one quarter of the four, which particular quarter varied by arrangement.

I do not remember, Senator, whether my last appointment to the University bore any reference to any specific period of time to which it applied, because my last appointment in the spring of 1929 was with the rank of full professor, and I have no recollection that it carried any specific time period. It was a permanent appointment and I do not recall more than that.

Senator DONNELL. At any rate you left in November.

Mr. FALK. Yes, I had resigned and I left at the end of that autumn quarter. Excuse me, I think it may have been the end of December. I think it was just before Christmas week that my resignation took effect and I left.

Senator DONNELL. Do you mind telling why you resigned that position?

Mr. FALK. Not at all, sir.

In the summer of 1929 or very late spring—I would have to verify the date—I was approached and asked whether I would be interested in taking an appointment with an organization known as the Committee on the Costs of Medical Care.

Senator DONNELL. Was Dr. Michael Davis associated with that committee?

Mr. FALK. Yes, he was.

Senator DONNELL. Was he the one that communicated with you in regard to that appointment?

Mr. FALK. I think not, though I am not sure. I think the first approach came from Mr. Harry H. Moore, director of study, of the committee. I think after the first communication from Mr. Moore I indicated an interest in possible employment with that committee and I think the next step was that Mr. Davis, who was a member of the executive committee, was asked to talk with me about it because both he and I were in Chicago then. I was invited to attend a meeting of the executive committee of the Committee on the Costs of Medical Care.

That was some time in the summer of 1929. I remember attending that meeting in Burlington, Vt.

After my return to Chicago, I remember some discussions were had, I think they were by correspondence, with the chairman of the department of the university; and after that with the vice president of the university. There was an exploration of the pros and cons, whether I would stay with the university or accept this employment. The complication in the matter was that the Committee on Costs of Medical Care wanted me to come for a period which I think was to be something over 2 years up to the end of their 5-year program of studies.

The proposal was put up to the university officials in terms of my taking that appointment with the committee on a leave of absence from the university. There was some question whether the university could afford to give a member of a department with a very small faculty leave of absence for so long a period, and we explored that, pro and con. When the decision was made that the university could not give me a leave of absence for so long, my request to the vice president became an offer of my resignation. It was accepted by the university with regret, to take effect at the end of the autumn quarter of that year.

As I remember the facts, at the end of the autumn quarter I left the university and joined the Committee on the Costs of Medical Care.

Senator DONNELL. You say the resignation was accepted with regret?

Mr. FALK. Yes, sir.

Senator DONNELL. Do you have that letter?

Mr. FALK. Yes, sir.

Senator DONNELL. With you this morning?

Mr. FALK. Yes. If there is no objection, may I have my secretary sit up here with me, because she knows where my papers are?

Senator DONNELL. Certainly not. It is all right.

Mr. FALK. I have here, Senator, the letter which I wrote on this matter to the chairman of the department.

Senator DONNELL. This is the original letter or a copy?

Mr. FALK. This is a copy made directly from the original, which is in my file.

Senator DONNELL. Very well.

Mr. FALK. I have a letter I addressed to Mr. F. C. Woodward, vice president, University of Chicago. I have Mr. Woodward's reply, and I have a letter from the secretary of the board of trustees.

Shall I read them, sir?

Senator DONNELL. Well, if you please.

Mr. FALK. The first is a letter of August 5, 1929, to Professor Jordan, who was chairman of the department of hygiene and bacteriology in the University of Chicago, a very distinguished scientist.

It reads:

> Prof. E. O. JORDAN,
> *Flossmoor, Ill.*
>
> DEAR DR. JORDAN: You will recall that before you left I told you of my luncheon conference with Dr. Michael Davis and that he had asked me whether I might be interested in the work of the Committee on the Cost of Medical Care.

Senator DONNELL. Could I interrupt you there in view of the fact you stated a few moments ago it was not with Dr. Davis you had your initial contact with the committee but it was with Mr. Moore. Does that not refresh your memory that it was with Dr. Davis and not Mr. Moore?

Would you mind repeating that last sentence, please?

Mr. FALK. May I add a sentence?

Senator DONNELL. Surely.

Mr. FALK. I think I had a letter from Dr. Moore first, but I would want to search the files and determine whether or not that is correct. If it is, I shall be very glad to submit that letter or a copy, if there is such a letter.

Senator DONNELL. Would you mind rereading what you have already read?

Senator MURRAY. Read it all over again so it will be connected.

Mr. FALK (reading):

> DEAR DR. JORDAN: You will recall that before you left I told you of my luncheon conference with Dr. Michael Davis and that he had asked me whether I might be interested in the work of the Committee on the Cost of Medical Care. Some days later Dr. Moore invited me to attend the conferences of the executive committee in Burlington.

Senator DONNELL. Some days later Dr. Moore issued the invitation?

Mr. FALK. Invited me [reading]:

> While, there, he offered me an appointment as associate director of the staff of the committee. The enclosed letter has come since then.

I am sorry, sir, I do not have that letter here. (Continuing:)

> I am prepared to accept Dr. Moore's invitation from the end of the autumn quarter for 2 to 2½ years (until June 30, 1932) if the necessary arrangements can be made in the university. A decision in the matter is urgently pressing because of Moore's needs and because I am extremely anxious to settle my own

plans for work (we must settle directly our program for animal and human influenza experiments). Several days have already elapsed since Dr. Moore has pressed me for a reply. But I have preferred to delay negotiation of a release from the university until there has been an opportunity to discuss the problem first with you personally.

I should appreciate it very much if you will telephone me tomorrow (Friday) concerning the earliest hour when you can discuss the matter with me.

I am sorry it has proven necessary to bother you at this time.

Yours sincerely,

And signed by myself.

Senator DONNELL. The date of that letter was what?

Mr. FALK. August 5, 1929.

The next letter I have, Senator, is dated September 24, 1929, addressed to Mr. F. C. Woodward, vice president, University of Chicago, Chicago, Ill., and reads:

DEAR SIR: In accordance with the arrangements discussed with you on September 9, 1929, I am now prepared to accept the invitation to join the Committee on the Cost of Medical Care as associate director of the staff.

I beg to present herewith my petition that I be granted a leave of absence by the University of Chicago for a period of 2½ years from the close of the autumn quarter, 1929, to June 30, 1932. In the event that this leave be granted I shall be glad to maintain contacts with the department of hygiene and bacteriology and to continue to supervise studies now in progress by members of the staff and by students in the department.

In the event that the granting of a leave for this period be considered to inconvenience seriously the program of the department of hygiene and bacteriology, I beg that this petition be construed as a resignation from the faculties of the University of Chicago, to take effect upon the close of the autumn quarter, 1929.

May I again take the opportunity to express my acknowledgment of the generous grants-in-aid that have facilitated my researches in the University of Chicago.

Very truly yours,

and signed by myself, with a notation "copy to Prof. E. O. Jordan."

The next letter, on the letterhead of the University of Chicago, office of the vice president and dean of faculties, dated September 28, 1929, reads as follows:

MY DEAR MR. FALK: I regret very much to have to say that we think it is not feasible to grant you a leave of absence for such a long period as 2½ years. We are therefore compelled, as you suggest, to treat your letter of September 24 as a resignation.

It is hardly necessary for me to say that I am very sorry to see you go. The appropriations which I have recommended for your research work evidence my high opinion of your ability and my confidence in you. I sincerely hope that you will find your new position congenial, and that you will have the best of luck.

Yours cordially,

and signed by Frederic Woodward.

The next letter, on the letterhead of the University of Chicago, the board of trustees, office of the secretary of the board, October 17, 1929, addressed to Mr. I. S. Falk, department of hygiene and bacteriology faculty exchange, reads as follows:

DEAR MR. FALK: The board of trustees of the University of Chicago, at its meeting held October 10, 1929, accepted your resignation, effective December 31, 1929.

I venture to express the regrets of the university that you are leaving the institution and wish you the greatest success in your new position.

Very truly yours,

signed John T. Moulds, secretary.

Senator DONNELL. Mr. Falk, when you were with the University of Chicago, did you also occupy a position as director of surveys of the Chicago Department of Health?

Mr. Falk. Yes, Senator, I did, and I have tried, since I anticipated some of these questions might be asked of me, I have tried to determine precisely the dates.

I was a little surprised when I went digging into such limited files as I have to find I could not exactly determine the date.

I noticed in some of my biographical material that I was director of surveys of the city of Chicago at that time, but I have found some correspondence which leads me to question whether I was director of surveys during the whole period between 1925 and 1927, or whether I was doing the work of that director as acting director part of the time and held the position only formally part of the time.

I know that within that period, 1925–27, I held that position and worked in the department of health, but for how long it was precisely that position, I am not sure.

Senator Donnell. You were in the Chicago Department of Health in the neighborhood of 2 years while you were with the University of Chicago?

Mr. Falk. Yes, that is correct.

(For later information on this point, see testimony of Mr. Falk of January 27, 1948.)

Senator Donnell. Did you know Dr. Arnold H. Kegel, commissioner of health?

Mr. Falk. I knew him very little and very briefly before leaving the department of health.

Senator Donnell. I will ask you whether you saw the Chicago Daily Tribune of Friday, December 23, 1927, which states: "Dr. Kegel ousts health official; expect shakeup. U. of C. man dismissed by new department chief"? The article itself goes on to state:

> Dismissing Dr. I. S. Falk as director of the division of surveys, Health Commissioner Arnold H. Kegel yesterday made the first change in the personnel of the city health department since he was named to succeed Dr. Herman N. Bundesen 3 weeks ago.

Do you remember seeing an article of that kind in the Chicago Tribune?

Mr. Falk. Yes, I have a copy.

Senator Donnell. If you will glance through that article, please. May I call your attention to this portion of the article and ask you to comment:

> Dr. Falk's ouster, it was understood, will be followed within a few days by the ousting of several other division and bureau chiefs in the department in a wholesale shuffle of jobs that will give Dr. Kegel an almost entirely new staff. At least one assistant commissioner, it was understood, will be replaced.
>
> Dr. Falk had held the post of director of surveys since January 1, 1926, drawing a salary of $3,600 a year. He is also an instructor in bacteriology on the faculty of the University of Chicago.

Can you tell us whether that is a correct statement of the facts? And if you have any comment to make with respect to it, please do so.

Mr. Falk. Senator, I would not profess to be able to recall at this time all of the details that are involved in one way or another with what is in that article.

I have tried to think about it since the chairman invited me to appear before this subcommittee. I anticipated this might be brought up, because a good deal has been made of it in various publications by Mrs. Shearon with respect to charges she has made or is reputed to have made that I was dismissed from the university as well as dismissed from the city department of health.

That item in the Chicago Daily Tribune, which you have just read, Senator, on its face, as long as you have asked me for comment, would indicate that the new commissioner of health came into the department and proceeded to prepare the ground for "a wholesale shuffle of jobs" that would give him an "almost entirely new staff."

My recollection of the facts is somewhat of this nature, that the commissioner of health of the city of Chicago, Dr. Herman N. Bundesen, was dismissed with no warning or notice, and that Dr. Kegel was appointed commissioner, and that directly after he took office he indicated it was not congenial to him to have in the department staff various members who had been recruited during Dr. Bundesen's incumbency.

Senator PEPPER. Has this Dr. Bundesen, who was your chief in the department of public health, since that time again become connected with the city of Chicago?

Mr. FALK. Senator, I would have come to that later. I do not remember the date but Dr. Bundesen later again became commissioner of health of the city of Chicago. That would have been somewhere about 1932 and, to the best of my knowledge, he is still commissioner of health of the city of Chicago.

Senator PEPPER. Thank you.

Mr. FALK. As to the surrounding circumstances under which I resigned from the city department of health, and I have reference to the item which the chairman read referring to alleged facts that I had prepared for publication a paper citing statistics purporting to show reduction of tuberculosis under Dr. Bundesen's regime, I have no independent recollection of that.

Senator DONNELL. That is you have no recollection of whether you did prepare such a statement?

Mr. FALK. I have no independent recollection as to whether any matter of that particular kind was or was not connected with my leaving. I do remember I prepared a paper with reference to tuberculosis mortality and morbidity.

Senator DONNELL. May I just interrupt you, Mr. Falk, a second? Is it correct, as quoted, that some of the statistics referred to in the paper of which you are supposed to be the author were misinterpreted in behalf of his predecessor and "he called on Dr. Falk for an accounting. In the clash which followed, Dr. Falk resigned"?

Do you remember whether or not that is a true statement of facts?

Mr. FALK. I have no recollection, Senator, of that clash, or what the important point or item was that led up to it. All I know at this time, to date, is what is in this item in the Chicago Tribune.

Senator DONNELL. You have no recollection that Dr. Kegel made the charges against you in the use of these statistics in that you had drawn a misinterpretation of them in behalf of Dr. Bundesen? You have no recollection of that at all?

Mr. FALK. No, sir, other than that which this item in the newspaper gives me.

Senator DONNELL. Does it give you any recollection on that subject?

Mr. FALK. I am sorry, it does not. I should not be at all surprised if Dr. Kegel made such a charge. I do remember that he was casting about to find some nominal grounds for dismissing a number of the senior members of the staff of the department.

Senator DONNELL. Including yourself?

Mr. FALK. Including myself.

Senator DONNELL. And he did, did he not, make the charge against you at that time in connection with the performance of your official duties that the statistics you prepared had been so interpreted by you as to cast a light on his predecessor which should not have been cast. Is that correct?

Mr. FALK. I only know what the item says.

Senator DONNELL. Would you say it is true or not true?

Mr. FALK. I would not say whether he did or did not make the charge, because I have no independent recollection of the facts.

Senator DONNELL. You have no independent recollection of whether Dr. Kegel made that charge?

Mr. FALK. That is correct.

Senator DONNELL. Did Dr. Kegel want you to stay or to get out?

Mr. FALK. He wanted me to get out.

Senator DONNELL. You might have a clipping from the Chicago Daily Tribune of Thursday, January 12, 1928, with you. If you do, could you refer to that?

Mr. FALK. I have a copy of that clipping. All I know is what is in this copy.

Senator DONNELL. You have no recollection yourself?

Mr. FALK. Senator, I did not recall any of these items at all. I found them as footnote reference in one of Mrs. Shearon's publications.

Senator DONNELL. And those footnote references were that he had resigned from both under fire. That is the statement in her publication entitled "Blueprint for the Nationalization of Medicine." She gives three references.

Mr. FALK. I am sorry. My page reference does not agree with yours.

Senator DONNELL. Page 8 of her booklet. I think you will find it at the bottom.

Mr. FALK. No, sir.

Senator DONNELL. We have different editions. This is the third edition I have here.

Senator MURRAY. I ask that the 17 other editions be introduced in the record.

Mr. FALK. I have a document——

Senator DONNELL. Would the Senator like to have this document incorporated in the record?

Senator MURRAY. I have no objection to anything. You can fill a boxcar with it.

Senator DONNELL. I offer, then, the pamphlet entitled "Blueprint for the Nationalization of Medicine" by Marjorie Shearon, Ph. D.——

Senator MURRAY. The chairman said no one would read the record anyway.

Senator DONNELL. I can understand that. I will offer at this time the three editions of Dr. Shearon's book entitled "Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Unwarranted Regulative Interference."

Senator MURRAY. I object unless you introduce the first and second editions.

Senator DONNELL. I will introduce them all.

Senator MURRAY. And any subsequent editions.

Senator DONNELL. Put them all in. There may be some in the future.

Senator MURRAY. There are some coming and I want it understood before the hearings are closed all of the subsequent editions will be put in the record.

Senator DONNELL. Very well.

(The chart referred to and ordered to be inserted previously at p. 1208 of part 3 of these hearings is inserted at this point.)

(Following is the third printing of Blueprint for the Nationalization of Medicine:)

BLUEPRINT FOR THE NATIONALIZATION OF MEDICINE[1]

PLANS TO ENCHAIN MEDICINE BY UNWARRANTED REGULATIVE INTERFERENCE

(By Marjorie Shearon, Ph.D., legislative consultant, formerly analyst, Social Security Administration and United States Public Health Service; lately consultant Senate Committee on Labor and Public Welfare)

INTRODUCTION

Definitions.—Since Senator Wagner and those who use him as a sounding board have consistently denied that national compulsory sickness insurance is socialistic or that it is state medicine, it may be well to define these terms before considering the blueprint for nationalization of medicine. In the latest edition of Webster's unabridged dictionary "socialism" is defined as—

"A political and economic theory of social organization based on collective or governmental ownership and democratic management of the essential means for the production and distribution of goods; also, a policy or practice based on this theory. Socialism aims to replace competition by cooperation and profit seeking by social service, and to distribute income and social opportunity more equitably than they are now believed to be distributed. These aims have given rise to many distinct schools" (among them, collectivism in France, nationalism in America, state socialism in Germany, and bolshevism in Russia).

It is noted by Webster that "Socialism favors a great extension of governmental action" and that "On questions of policy, opportunist or conservative socialists believe in a slow evolutionary transformation of capitalist into socialist society * * *."

State socialism is defined as "A form of socialism prevalent in Germany and Great Britain, which advocates utilizing the power of the state to equalize income and opportunity by measures such as progressive income and inheritance taxes and compulsory insurance against old age, unemployment, sickness, and accident, and by state administration of industries, public utilities, common carriers, banking, housing, and the like." Thus, by definition, compulsory sickness insurance is one of the measures utilized by the state to equalize income and opportunity in countries having a state socialist form of government. Indeed, compulsory insurance was an essential part of the fiscal and regulatory machinery devised by Bismarck's economic adviser and was acclaimed as the "high-water mark of state socialism."[2]

Webster defines state medicine as "medical treatment provided or controlled by a government and subsidized by public funds." Under such a definition, I think it would be agreed that a national compulsory sickness insurance scheme when fully developed for the entire population would be state medicine with medical treatment provided or controlled by the Federal Government and subsidized by public funds. The funds would be "public" whether they were derived from social-security taxes, "premiums," "contributions," or income taxes. Doctors would be paid by the Government in whole or in part on a salary basis

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[1] Presented in part at the annual meeting of the Association of American Physicians and Surgeons, Palmer House, Chicago, November 8, 1946.

[2] Shearon, Marjorie, An Analysis of Current Bills, in Compulsory or Voluntary Health Insurance, National Industrial Conference Board, May 16, 1946, p. 12.

NT TRUMAN

L M. DAVIS
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nt to FALK

S. SANDERS
nd Disability
Chief, SSB

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Sturges, M. D.

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, Chairman
Y, Ph. D., SSB
Perrott, PHS
ly, M. D., CB
U. of Mich.

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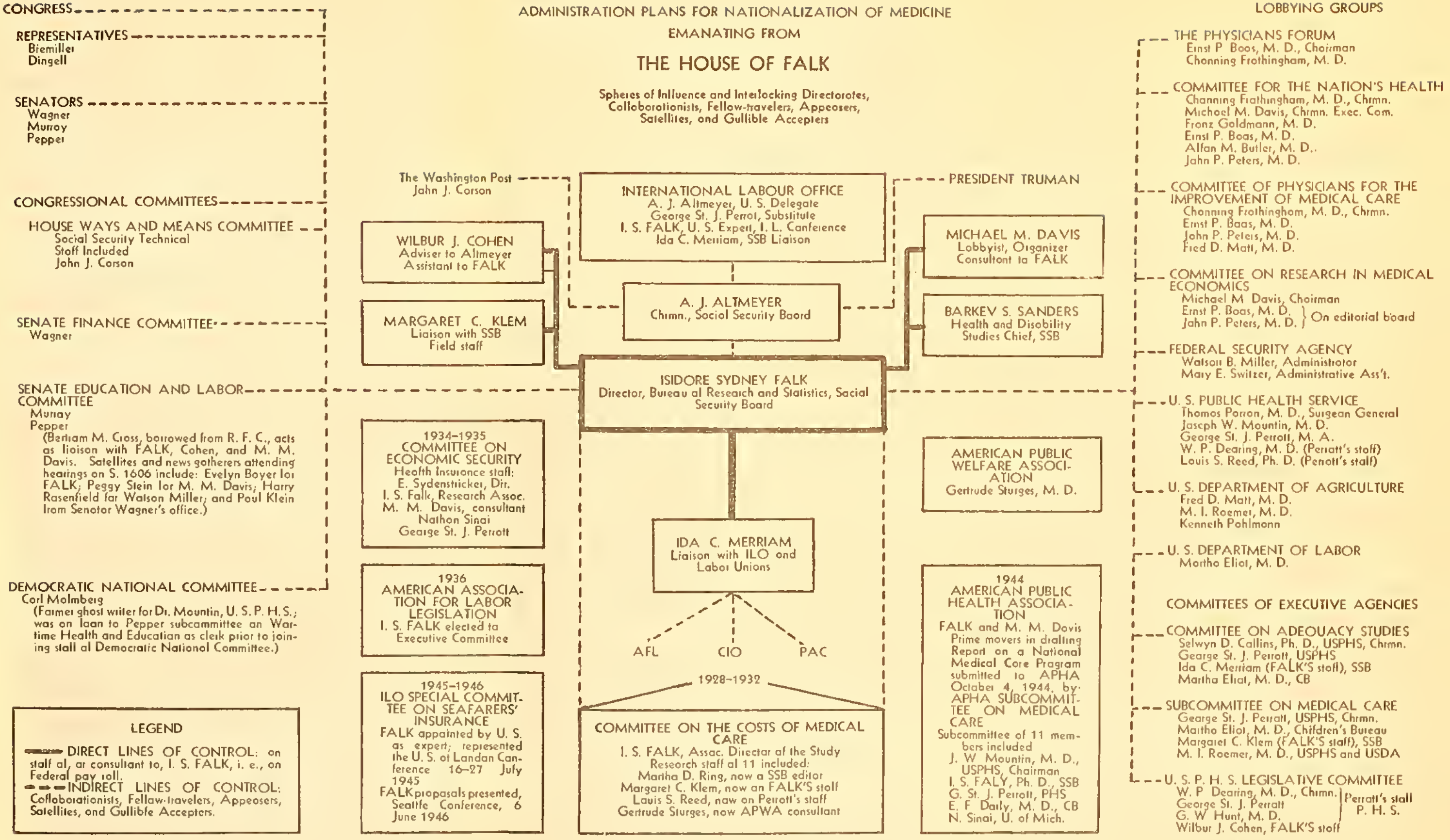

ADMINISTRATION PLANS FOR NATIONALIZATION OF MEDICINE
EMANATING FROM

THE HOUSE OF FALK

Spheres of Influence and Interlocking Directorates, Collaborationists, Fellow-travelers, Appeasers, Satellites, and Gullible Accepters

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REPRESENTATIVES
Biemiller
Dingell

SENATORS
Wagner
Murray
Pepper

CONGRESSIONAL COMMITTEES

HOUSE WAYS AND MEANS COMMITTEE
Social Security Technical Staff Included
John J. Corson

SENATE FINANCE COMMITTEE
Wagner

SENATE EDUCATION AND LABOR COMMITTEE
Murray
Pepper
(Bertram M. Gross, borrowed from R. F. C., acts as liaison with FALK, Cohen, and M. M. Davis. Satellites and news gatherers attending hearings on S. 1606 include: Evelyn Boyer for FALK; Peggy Stein for M. M. Davis; Harry Rosenfield for Watson Miller; and Paul Klein from Senator Wagner's office.)

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Carl Malmberg
(Former ghost writer for Dr. Mountin, U. S. P. H. S.; was on loan to Pepper subcommittee on Wartime Health and Education as clerk prior to joining staff of Democratic National Committee.)

LEGEND
▬▬ DIRECT LINES OF CONTROL: on staff of, or consultant to, I. S. FALK, i. e., on Federal pay roll.
‒ ‒ ‒ INDIRECT LINES OF CONTROL: Collaborationists, Fellow-travelers, Appeasers, Satellites, and Gullible Accepters.

The Washington Post
John J. Corson

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George St. J. Perrott, Substitute
I. S. FALK, U. S. Expert, I. L. Conference
Ida C. Merriam, SSB Liaison

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Health and Disability
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ISIDORE SYDNEY FALK
Director, Bureau of Research and Statistics, Social Security Board

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Nathan Sinai
George St. J. Perrott

AMERICAN PUBLIC WELFARE ASSOCIATION
Gertrude Sturges, M. D.

IDA C. MERRIAM
Liaison with ILO and Labor Unions

AFL
CIO
PAC

1936
AMERICAN ASSOCIATION FOR LABOR LEGISLATION
I. S. FALK elected to Executive Committee

1945–1946
ILO SPECIAL COMMITTEE ON SEAFARERS' INSURANCE
FALK appointed by U. S. as expert; represented the U. S. at London Conference 16–27 July 1945
FALK proposals presented, Seattle Conference, 6 June 1946

1928–1932
COMMITTEE ON THE COSTS OF MEDICAL CARE
I. S. FALK, Assoc. Director of the Study
Research staff of 11 included:
Martha D. Ring, now a SSB editor
Margaret C. Klem, now on FALK'S staff
Louis S. Reed, now on Perrott's staff
Gertrude Sturges, now APWA consultant

1944
AMERICAN PUBLIC HEALTH ASSOCIATION
FALK and M. M. Davis
Prime movers in drafting Report on a National Medical Care Program submitted to APHA October 4, 1944, by:
APHA SUBCOMMITTEE ON MEDICAL CARE
Subcommittee of 11 members included
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I. S. FALY, Ph. D., SSB
G. St. J. Perrott, PHS
E. F. Daily, M. D., CB
N. Sinai, U. of Mich.

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Wilbur J. Cohen, FALK'S staff

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(as is proposed under the current national health service bill in Great Britain) or on a capitation basis which would be close to a dead-level salary. The fee-for-service basis is almost out of the question administratively, although in propaganda pamphlets doctors and patients alike are told that this would probably be the preferred method of payment. However, Ernst P. Boas, M. D., chairman of the Physicians Forum and one of the leading advocates of compulsory sickness insurance, conceding the necessity for salaried or capitation methods of payment, has said:

"Insurance guaranteeing complete medical coverage cannot be set up, except at a prohibitive cost, if the fee-for-service principle is retained."[3]

With these definitions and frames of reference we are now ready to consider how the nationalization movement developed in this country.

Socialization plans have been revealed.—Hitler, in Mein Kampf, set forth his plans for world conquest; the International Labour Organisation, in its reports on social insurance, has described the international pattern for socialization of medicine, country by country; and the Social Security Administration,[4] in its publications and draft legislation, has revealed its plans for nationalization of medicine in the United States. People failed to take seriously the avowed intentions of Hitler. Will the same mistake be made of failing to take seriously the avowed intentions of the ILO and of the Social Security Administration?

Long before his ascension to power, Hitler recognized the need of two things: a blueprint and a propaganda machine. That same need was recognized by the leaders of the socialization movement in this country. During the past two decades they have perfected both the blueprint and the propaganda machine. More than that, the leaders of the movement have instilled into their followers the zeal and determination which characterize crusaders and reformers the world over. Unfortunately, it must be said of the opponents to socialization, as it was said of the opponents to Hitler before the war: "The forces in opposition have lacked the clearness of plan, the unity of motive, the certainty of conviction, needed to make their cause prevail."[5]

If those opposed to Government control of medicine are to arrive at a clear plan of action and are to attain unity of motive and certainty of conviction, it is imperative for them to identify the members of the inner ring who have created the propaganda machine and made the blueprint for nationalization.

EVOLUTION OF PLANS AND PROPAGANDA

Three critical periods.—In tracing the nationalization movement in this country we must go back some 35 years to the time when the earliest social insurance laws were passed in the United States. The first period, from 1911 to 1925, was one of diffuse efforts. The second, from 1926 to 1934, was marked by the organization of private groups and the gathering of a sizable body of documentary material on medical economics. The third, from 1935 to 1947, was characterized by infiltration of the socializers into the Federal Government.

In 1911, 10 States enacted workmen's compensation laws. That was the year in which Lloyd George succeeded, against great opposition, in forcing through Parliament the National Insurance Act which brought to Great Britain a scheme of compulsory sickness insurance for wage earners. These developments led to scattered efforts in this country to arouse public interest in all types of social insurance. However, the early reformers were not well organized, and the socialization movement languished. Arthur J. Altmeyer's connection with compulsory sickness insurance plans dates back to this period.[6]

In the late twenties a revival of interest in socialized medicine was stimulated by Michael Marks Davis, doctor of philosophy, director of medical services for the Rosenwald Fund. He had joined that organization in 1928, after having been director of a dispensary in Boston for 10 years and an organizer of pay clinics in New York for 7 years. Davis favored socialization of medicine by (1) integrating preventive and curative measures, (2) distributing costs through taxation and insurance principles, and (3) organizing medical services so that general practitioners and specialists would carry on their activities as group practitioners in hospitals and clincs.

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[3] Boas, Ernst P., M. D., Why Do We Need Health Insurance? No date, p. 13.

[4] Under Reorganization Plan No. 2 of President Truman, which became effective July 16, 1946, the name of the Social Security Board was changed to Social Security Administration and the functions of the Board were transferred to the Federal Security Agency. The three-man board was abolished. The Chairman of the Social Security Board, Arthur J. Altmeyer, became Commissioner of Social Security. He has also been appointed Assistant Federal Security Administrator by Watson B. Miller, FSA Administrator, and is thus elevated to a higher administrative echelon.

[5] Hitler, Adolph, Mein Kampf, New York, 1939, p. xi.

[6] Commons, John R., and Altmeyer, A. J., The Health Insurance Movement in the United States, in Report of the Health Insurance Commission of the State of Illinois, May 1, 1919, pp. 625–647.

During the twenties Davis was joined by Isidore Sydney Falk, a man 20 years his junior, whose prior experience had been almost entirely academic and scientific. Falk, after taking his doctor of philosophy degree in bacteriology at Yale, had spent 5 years on the faculty of the Chicago Medical School * and 2 years in the Chicago Department of Health. He had resigned from both positions under fire.[7] Shortly before leaving Chicago in December 1929, he had received considerable publicity in the press as the "discoverer" of the germ of "flu" and had put forth the claim that a cure might soon be forthcoming. The "discovery" was questioned. Falk's scientific career in bacteriology came to an abrupt end. At that time the following statement appeared in the Journal of the American Medical Association:

"With little if any apparent warrant, it is again announced, for at least the tenth time in 5 years, that the causative organism of influenza has been discovered and that it is hoped to prepare a vaccine. There is thus far little or no evidence in scientific medical literature, or even in spoken addresses, to indicate that I. S. Falk, doctor of philosophy, and his associates have progressed any further toward the solution of this problem than have workers in other parts of the world, now or in the past * * *. The furore is inexcusable."[8]

On leaving Chicago Falk joined the Committee on the Costs of Medical Care as associate director of research. That committee, which Michael M. Davis had helped to organize in 1927 "to make a comprehensive survey of the economics of medical care in the United States."[9] was financed by gifts of nearly $900,000 from 8 foundations including the Julius Rosenwald Fund, the Milbank Memorial Fund, the Rockefeller Foundation, and the Twentieth Century Fund. The CCMC published 28 volumes of which the most frequently quoted are the last two: "The Costs of Medical Care" by Falk, Rorem, and Ring; and the final report of the committee, "Medical Care for the American People."

The publications of the CCMC have been one of the mainstays of the State medicine propaganda effort. They are still being quoted by the leaders of the movement though the statistics are out of date. It is not the purpose of this discussion to give a critique of CCMC findings and recommendations other than to point out that that committee after 5 years' study did not come out with a majority recommendation for compulsory sickness insurance. Instead, they proposed promotion of voluntary health insurance plans, expansion of public health services, coordination of medical services, improvements in medical education, and other noncontroversial procedures.

During the period from 1926 through 1934 the necessary groundwork was being laid. Davis and Falk, generously supported by a number of foundations, brought together the scattered activities of the social reformers and gradually took over the program for socialization of medicine in the United States. The period was one of organization, development of slogans, enunciation of principles, and stimulation of pressure groups. Upward of $2,000,000 of private funds, possibly more, was used to lay the foundations for development of the powerful propaganda machine which was set in motion in the ensuing period from 1935 to 1947.

American socialization leaders adopt Bismarck's blueprint.—These two leaders, Davis and Falk, appropriated, organized, and propagandized; they did not originate. The plan to bring medicine under State control had its origin in central Europe, having been part of the larger program of state socialism put into effect in Germany in the 1880's. As I have pointed out elsewhere, it has been said that Bismarck's aim was "first to muzzle the official Social Democrats, and then, by a series of small bribes, to wean the proletariat from their adherence to revolutionary principles."[10] It will be recalled that the main purpose of the Bismarckian laws of social insurance was to attach the workers to the state and to launch a new taxing program which would raise revenues and at the same time fulfill the purpose of "regulative interference." This interference was designed to redistribute wealth and to regulate the purchasing power of the "lower classes."

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[7] "Dr. Kegel Ousts Health Official: Expect Shake-up. U. of C. Man Dismissed by New Department Chief," Chicago Tribune, December 23, 1927; see also Chicago Tribune, January 12, 1928, and December 15, 1929.

[8] The Influenza Discovery (?), Journal American Medical Association, vol. 93, No. 25, p. 1975, December 21, 1929.

[9] Julius Rosenwald Fund, Chicago, 1937, p. 17; Medical Care for the American People, CCMC Publication No. 28, pp. vi–viii.

[10] Shearon, Marjorie, An Analysis of Current Bills, in Compulsory or Voluntary Health Insurance, National Industrial Conference Board, May 16, 1946, p. 12.

* COMMITTEE EDITOR'S NOTE.—In May 25, 1948 testimony Dr. Shearon volunteered the following correction: Substitute "University of Chicago" for "Chicago Medical School." For further explanation see testimony of that date.

Compulsory sickness insurance, which was one part of the Bismarck scheme, was at first resisted by organized labor, but was later embraced by national and international labor groups who apparently thought more of the "small bribes" than of their freedom. Justification for imposition of state control of medicine through compulsory sickness insurance legislation was set forth by the International Labour Organisation in 1927 in these words:

"*The modern State, as guardian of public health and national prosperity considers it both a right and a duty to impose compulsion. Even the devotees of individualism admit * * * that insurance is a social duty the performance of which the State may, in the general interest, enforce.* [Italics mine.]

"Germany in 1883, without making lengthy experiments with the voluntary method, was the first to make sickness insurance compulsory for industrial workers; * * *

"This creation of Bismarck's, so keenly opposed at first by the German working class, was doubtless inspired by a political motive. *Its purpose was to attach workers to the State* as the defenders of the capitalist system. [Italics mine.]

"When the State makes insurance compulsory and requires insured persons and employers to pay contributions, it is its right and duty to supervise the regular working of the insurance system.

"In the first place the State must see to it that normal effect is given to the obligation of every person liable to insurance to join an insurance institution, * * *

"* * * *the supervisory authorities and their agents have the power of investigation.* [Italics mine.] They may examine on the spot all the documents connected with management, and have the right to inspect the establishments set up or used by the funds: dispensaries, hospitals, sanatoria, etc. * * * Sometimes, even, the supervisory authorities * * * may impose sanctions (warnings and fines). * * * The supervisory authority * * * is not merely the protector of the law, but also a technical and social adviser.

"If by the law the management of insurance is reserved to the State, it entrusts the administration to a ministry or public department set up for the purpose, together with its agents. * * *

"An insurance institution will have machinery for deliberation, execution, and supervision, though this is not always the rule. In many countries supervision is solely in the hands of the public authorities, and the law does not provide for independent supervisory machinery (Germany, Great Britain, Irish Free State, Japan)." [11]

The Shibboleths of the socializers.—In 1925, 2 years before the ILO laid down the principles for compulsory sickness insurance programs in the modern state, Hitler in *Mein Kampf* had set forth the precepts for effective propaganda, stating:

"All effective propaganda has to limit itself only to a few points and to use them like slogans until even the very last man is able to imagine what is intended by such a word. * * * Propaganda is not for the intelligentsia. * * * It has to appeal forever and only to the masses! * * * The more modest, then, its scientific ballast is, and the more it exclusively considers the feelings of the masses, the more striking will be its success."[12]

The Falk-Davis shibboleths have been limited to a few concepts used over and over like slogans, until the very last man can understand the ideas to be conveyed. The appeal has been made to the masses. The scientific ballast has been most modest. For 20 years, through books, pamphlets, the press, radio, forum discussions, and Senate hearings, the following slogans have been put forth by the propaganda machine:

"Medical services must be organized." "Health insurance must be compulsory." "Health insurance must be comprehensive." "Medical services must be furnished by groups of physicians and related practitioners." "Medical services must be available as a right." "The costs of medical care should be distributed over groups of people and over periods of time." "Freedom of choice should be guaranteed to patients and to doctors." "Our people would continue to get medical and hospital services just as they do now." "Health insurance is not socialized medicine." "Social security taxes are premiums, not taxes."

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[11] Compulsory Sickness Insurance, Comparative Analysis of National Laws and Statistics. International Labour Office. Studies and Reports, Series M (Social Insurance), No. 6, 704 pp., Geneva, 1927, pp. 10, 11, 607, and 658.

[12] Hitler, Adolph, Mein Kampf, New York, 1939, pp. 230, 233.

PROPAGANDA TECHNIQUES

Effective resistance to the forces working for State socialism requires an understanding of the exact manner in which the socialist propaganda machine has operated and is now operating. Three channels have been used by those who advocate governmental intervention in the distribution of medical services:

Private propaganda via pamphlets, principles, and programs.—Propaganda, liberally financed through the funds of private foundations and of individual philanthropists, has been organized mainly by Michael M. Davis who has disseminated pamphlets, drafted principles, and worked out programs. He has operated primarily through committees organized or dominated by one or another of the leaders in the socialization movement. Through these committees it has been possible to get into circulation ostensibly disinterested statements actually written by interested propagandists. Persons in the public eye, such as movie actors, presidents of large corporations, and the wife of an ex-President, have been induced to lend their names as "fronts" behind which the organizers operate. This private propaganda is timed to support legislation drafted by the organizers working inside the Federal Government.

Government propaganda via "research" reports, surveys, and draft legislation.—After working for 7 years under the tutelage of Davis in the private propaganda field of social "research," Falk graduated into the Federal civil service in 1936 where he took charge of the development of official governmental propaganda for compulsory sickness insurance. Through Federal information services and other media he has distributed directed "research" reports favoring compulsion and governmental control of medicine. Using Federal appropriations and civil service staffs, he has had an excellent opportunity to influence behind-the-scenes opinion in both the executive and legislative branches of the Federal Government. On the basis of reports and surveys which year after year have hammered home the shibboleths of socialization and, more recently, nationalization, Falk has promulgated principles and drafted compulsory sickness insurance legislation based on the principles outlined 20 years ago by the ILO and since elaborated by Falk himself.

Propaganda via labor organizations.—During his sojourn at the Milbank Memorial Fund (1933–36) Falk worked out his plan for compulsory sickness insurance and then began to enlarge his labor contacts here and abroad. At the annual meeting of the advisory council of the Milbank Memorial Fund on March 15, 1934, it was announced that the Milbank research staff, of which Falk was research associate, were working out a plan which aimed "to complete the work left unfinished by the Committee on the Costs of Medical Care." It was stated that "The staff members of the Milbank Fund see only in large-scale compulsory health insurance the necessary and sufficient stimulus for widespread improvement in medical practice."[13] At that meeting Harry Hopkins, Works Progress Administrator, joined in endorsing the program calling for compulsory health insurance. He is quoted as having said:

"You aren't going to get health insurance if you expect people to do it voluntarily. I am convinced that by one bold stroke we could carry the American people along not only for health insurance but also for unemployment insurance. I think it could be done in the next 18 months." [14]

The depression, the New Deal, and labor's rising tide concatenated a most unusual and auspicious set of circumstances for an opportunist. Falk capitalized on the entire situation, consistently playing a dual role after his career in bacteriology had ended in 1929. Professionally, he has clung to "research" positions in private, and later in public, organizations; pragmatically, he has wooed and used labor to achieve his ends. Some of the labor groups with which he has been associated are:

American Association for Labor Legislation

In 1934 Falk presented a paper entitled "Formulating An American Plan of Health Insurance" before the annual meeting of the American Association for Labor Legislation,[15] and 2 years later was elected to the executive committee of the association.[16] The organization is a policy-forming, lobbying group which carries out "its entire program through the tested methods of research, conferences, correspondence, publications, legislative drafting, and representation at public hearings."[17] Founded in 1906, the association had consistently favored passage of compulsory sickness insurance legislation and, in 1936, after enactment of the social security bill, had pointed out that health insurance was "the principal missing link in the administration's social securty program."[18] For many years, Altmeyer, Falk, and Wilbur J. Cohen have been active in this organization and, along with Michael M. Davis, have published numerous articles on sickness insurance in its official publication, the American Labor Legislation Review. There has been a strong tie-in of the association with the ILO. Carter Goodrich, chairman of the governing board of the ILO is also a member of the executive committee of the American Association for Labor Legislation.

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[13] State Insurance of Health Urged, New York Times, March 16, 1934, p. 12.

[14] Ibid.

[15] American Labor Legislation Review, XXIV, No. 2, June 1934, pp. 87–94.

International Labour Organisation

The second important labor group with which the Falk-Davis clique has been affiliated is the International Labour Organisation. When the ILO was set up in Geneva as a result of the Versailles Treaty of 1919, the United States was denied congressional authority to join. For 15 years this country officially remained aloof. Then in 1934 Congress enacted legislation authorizing the President to accept membership in the ILO for the United States. The legislation was jammed through in a characteristic manner. During the last-minute rush before Congress adjourned on June 18, 1934, a joint resolution was introduced in the Senate and on June 13 was passed without discussion.[19] The companion bill in the House evoked a short but violent blast from Congressman George Holden Tinkham, of Massachusetts, who pointed out that there had been no hearings on the bill, no witnesses, no reports from labor organizations. He said:

"If the House desires to commit the United States to internationalism under the direction and control of propagandists paid with money of foreign interests, then let the House vote for this resolution."[20]

Despite the fact that thoughtful consideration had not been given this important measure and that opportunity had not been provided for public discussion of the bill, the House gave its approval on June 16 with a two-thirds vote. President Roosevelt signed the bill on June 19, 1934, accepted ILO membership for the United States, and immediately, set in motion the machinery necessary to bring our Federal laws into conformity with the principles of state socialism advocated by the ILO.

It is well to remember that the ILO, which had been created for the laudable purpose of improving social conditions throughout the world, especially by establishing international standards in regard to hours, wages, and conditions of work, had been developed into an institution of tremendous power. The ILO had been dominated for a dozen years by its first director, Albert Thomas, who, before accepting that position, had been "one of the leaders of the French Socialist Party."[21] At the time of his death in 1932 he was described as "one of the most ardent pioneers of socialism,"[22] and it was claimed with pride that he had "stamped the organization he created with the seal of his personality."[23] Thomas had traveled from country to country and from continent to continent preaching "the gospel of Geneva!" Throughout those early formative years of the ILO when the United States was not a member, the organization policies had been shaped by this ardent pioneer of socialism who, reared in an environment totally different from our own, had become the exponent and fervent crusader for an ideology foreign to the thinking of the majority in the United States. This ideology, which had found its highest expression in state socialism, was responsible for inclusion, among other things, of a commitment on the part of ILO member nations, to extend compulsory social insurance, including sickness insurance, as fast as possible through exertion of pressure on the legislative bodies of those member nations. The United States, on becoming a member of the ILO in 1934, stepped squarely into the center of an avowedly Socialist set-up and accepted a commitment to further enactment of comprehensive social insurance laws as a national goal.

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[16] Loc. cit., March 1937, p. 46.

[17] Ibid.

[18] Ibid., p. 47.

[19] For history of this legislation in Congress see Congressional Record, vol. 78, pp. 12238–12240, 12450, 12453, 12577, and 12579.

[20] Ibid., p. 12240.

[21] In Memory of Albert Thomas, Geneva, 1932, p. 6; see also International Labour Review, XXV, No. 5, pp. i–iv, May 1932.

[22] Albert Thomas the First Director, International Labour Review, XXVI, No. 1, p. 6, July 1932.

[23] Albert Thomas, 1878–1932, Annemasse, Haute-Savoie, France, probably 1932, 122 pp., p. 69.

Frances Perkins, then Secretary of Labor, was the prime mover in paving the way for entry of the United States into the ILO. She asked, and received from President Roosevelt, "permission to go ahead and prepare the way for the United States to join the ILO." Nay, more. When the Economic Security bill (which became the Social Security Act) was being drafted, Secretary Perkins brought in André Tixier and Oswald Stein from the ILO as consultants. This was one of the early moves to bring our Federal legislation and our economy into line with the ILO Socialist pattern.[24]

I doubt if the vast majority of people in the United States knew anything at all about this commitment, which still exists, or had any idea how far-reaching would be the plans the Falk-Davis machine would develop under the protecting cloak of official authority and Presidential blessing.

AFL, CIO, AND PAC

After Falk became a Federal employee in 1936 he directed part of his attention to cultivating the American Federation of Labor and the Congress of Industrial Organizations. Within the Bureau of Research and Statistics in the Social Security Board, he created a special unit, innocently designated as the Division of Coordination Studies, to handle labor contacts and to write speeches, pamphlets, and reports for organized labor. Ida C. Merriam, labor economist, heads the division. She works closely with Katherine Ellickson, assistant director of research, CIO, and serves as a liaison with the ILO. While any too obvious connection with the Political Action Committee or its fund-raising affiliate, the National Citizens Political Action Committee, would have been frowned upon because of the Hatch Act, it has been possible to obtain the desired left-wing support through association with such members of NCPAC as Michael M. Davis, Will S. Alexander, Ernst P. Boas, and Raymond Walsh, research director of the CIO.

INFILTRATION OF SOCIALIZERS INTO FEDERAL GOVERNMENT

Foundation laid for national social insurance laws in the United States.—During 1933 President Roosevelt and his close advisers Secretary of Labor Frances Perkins and Federal Emergency Relief Administrator Harry Hopkins began to work on a plan of compulsory sickness insurance to be in included in a broad program for economic security.[25] Late in May 1934, the President outlined his New Deal which included in his permanent program "nation-wide insurance of workers against sickness." [26] One month later, on June 29, 1934, only 10 days after Congress had sanctioned our joining the ILO, President Roosevelt appointed the Committee on Economic Security the members of which were: Frances Perkins, Secretary of Labor, chairman, and Harry Hopkins, Federal Emergency Relief Administrator, together with Henry Morgenthau, Jr., Secretary of the Treasury, Homer Cummings, Attorney General, and Henry A. Wallace, Secretary of Agriculture.[27] When the technical staff for the Committee was set up it included a health insurance staff directed by Edgar Sydenstricker, scientific director of the Milbank Memorial Fund, aided by his research associate at the fund, I. S. Falk. Also on that staff were M. M. Davis, Nathan Sinai, George St. J. Perrott, Katharine F. Lenroot, and Martha M. Eliot. On January 15, 1935, the Committee on Economic Security reported its recommendations to the President. Two days later he sent his message to Congress recommending legislation on economic security and that same day the Wagner-Doughton economic security bill was introduced in Congress. It is worthy of note that the group of socializers was not then sufficiently powerful to prevail with the President in the light of other more potent considerations. Although favoring compulsory health insurance, Roosevelt failed to ask Congress to include such a scheme in the original economic security bill which, as rewritten and greatly amended, became the Social Security Act of August 14, 1935.[28]

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[24] For description of behind-the-scenes manipulations see Perkins, Frances, The Roosevelt I Knew, New York, 1946, pp. 339–346; for ILO consultants, ibid., p. 282. See further, Labor's Program to Socialize Medicine Internationally. Medical Economics, November 1945.

[25] For a full account of what transpired at this time see the excellent article by Frederic J. Quigley, M. D., then president of the Medical Society of New Jersey, entitled "The Philosophy of the Medical Society of New Jersey," the Journal of the Medical Society of New Jersey, vol. XXX, No. 6, pp. 320–326, June 1934. See also Perkins, Frances, loc. cit., pp. 288, 289, and 297.

[26] New York Times, May 20, 1934.

[27] Social Security in America, Washington, 1937, p. 516. For details on Creation and Membership of the Committee on Economic Security and Affiliated Groups see pp. 515–523. See also Perkins, Frances, loc. cit., p. 280.

Social Security Board becomes mecca for socialization leaders.—On August 23, 1935, Congress confirmed the appointment of John G. Winant, who later became Director of the ILO, as first chairman of the Social Security Board and Arthur J. Altmeyer as the second member of the 3-man board.[29] Walton H. Hamilton, professor of law at Yale University, and at that time on loan as one of the directors of the National Recovery Administration, was made first director of research and statistics in the Board. Hamilton, it will be recalled, had strongly advocated compulsory sickness insurance in his minority report to the Committee on the Costs of Medical Care.[30] On December 1, 1936, Isidore Sydney Falk, having left the Milbank Memorial Fund under fire was brought into the Social Security Board as a medical economist in the small Division of Planning and Analysis. Three persons who had been on Falk's staff at CCMC joined the Social Security Board and eventually found their way to Falk's staff again. They were: Louis S. Reed who became Assistant Chief of Health Studies on October 12, 1937; Margaret C. Klem who entered in 1936 and became Chief of Medical Economics in 1940; and Martha D. Ring, who entered as a member of the information staff and became one of the editors in the Division of Publications and Review.

Michael M. Davis was appointed on January 28, 1938, as Principal Consultant in Medical Economics in the Division of Health Studies headed by Falk. He was to receive all expenses and $18.05 a day up to 200 days in the year. George St. J. Perrott, a chemist, had already entered the Public Health Service in 1933 in the Office of Statistical Investigations. Thus, by the beginning of 1938, nearly all the more active workers in the movement for socialization of medicine had moved inside the Federal Government or were in a position to shape national policies in the role of consultant. Falk took over the reins from Davis who thereafter was in very truth a consultant, not the commander in chief. Once the leader and his henchmen were firmly intrenched in civil-service positions and had received Presidential authority to work out programs and propose legislation, the road for action was open. (See chart following p. 22 and Appendixes A and B.)

National social insurance laws projected by Roosevelt.—In August 1935, immediately following passage of the Social Security Act, President Roosevelt had appointed the Interdepartmental Committee to Coordinate Health and Welfare Activities in the Federal Government. Membership included: Josephine Roche, Assistant Secretary of the Treasury, chairman; Arthur J. Altmeyer, Chairman, Social Security Board; Oscar L. Chapman, Assistant Secretary of Interior; Charles V. McLaughlin, Assistant Secretary of Labor; and Milburn L. Wilson, Under Secretary of Agriculture. In October 1938 the President had added to the committee Dr. Thomas Parran, Surgeon General of the Public Health Service, and Aubrey Williams, Deputy Administrator, Works Progress Administration. George St. J. Perrott of the Public Health Service was made secretary. In October 1936 the Interdepartmental Committee appointed a Technical Committee on Medical Care which ultimately included Falk of the Social Security Board, Mountin, Perrott, and Waller of the Public Health Service, and M. Eliot of the Children's Bureau, chairman.[31]

The membership of these two committees harks back to the days of the Committee on Economic Security and also gives a preview of the membership of other committees that were to be appointed during the following decade when the same little group of Government officials would be seen working together on self-perpetuating committees to bring about an ever-increasing measure of Federal control of medicine. During the period 1936 to 1947 top leadership was provided by Falk. Some officials served as willing collaborators, others as reluctant collaborationists. Some were duped and never clearly saw the over-all plan, while others followed the state Socialist or Communist line as fellow travelers, not initiating, yet not resisting, subversive movements.

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[28] Message of the President Recommending Legislation on Economic Security. H. Doc. No. 81, January 17, 1935, p. vi. See also Toward Economic Security, Comments on Economic Security, symposium broadcast March 16, 1935, and Perkins, loc. cit., p. 297.

[29] Congressional Record, vol. 79, p. 14305, August 23, 1935, Frances Perkins, loc. sit., p. 300, states that she suggested these two men to President Roosevelt who then appointed them to the Board.

[30] Medical Care for the American People, CCMC Publication No. 28, Chicago, 1932, pp. 189–200.

[31] Social Security Bulletin, I, 1–3, p. 4, March 1938; and Proceedings National Health Conference, July 18, 19, 20, 1938, Washington, p. viii.

Late in 1937 the Technical Committee on Medical Care completed a report which was transmitted to the President from the Interdepartmental Committee. On the recommendation of the latter Committee the first National Health Conference was called in Washington in July 1938. The modest recommendations for legislative action made by the committee at that time were quite at variance with proposals made by the same group a bare five years later after they had strengthened their organization and had attained greater power.

The medical-care provisions of the 1939 Wagner health bill, implementing the recommendations of the Interdepartmental Committee, were drafted under Falk's direction. Following hearings, the report for the subcommittee of the Committee on Education and Labor recommending further study and a new draft bill was written under Falk's direction. Congress failed to act on the legislation. It is worthy of note that Falk did not then claim that the only road to national health in this country was via federally controlled compulsory sickness insurance. The 1939 bill simply proposed grants-in-aid to the States for specified health activities including medical-care services; the method of financing, whether by general taxation or compulsory insurance, was optional with the States.

Consolidation of gains and assumption of prerogatives.—One of the main reasons why so little progress was made in the socialization movement during the 4 years from 1936 to 1940 was that Falk's position was obscure, his staff small, his budget insignificant. He entered the Social Security Board on December 1, 1936, as Principal Medical Economist in the Division of Analysis and Planning, in the Bureau of Research and Statistics, several steps below the directorship. Walton H. Hamilton was then Director, Ewan Clague, Associate Director, and Thomas C. Blaisdell, Jr., Assistant Director. Months passed. Then a Division of Health Studies was created and Falk was made its chief at $6,400 on August 3, 1937. That fall Hamilton resigned, and on November 1, 1937, Clague became Director. Blaisdell continued as Assistant Director, and Falk was given the seemingly empty title of Acting Assistant Director of the Bureau in addition to his title as chief of one of the divisions in the Bureau.[32] Blaisdell resigned on July 15, 1938, and on November 7 of that year Falk took the next step up, succeeding to Blaisdell's title and $6,500 salary. Within less than a month a salary increase of $500 was forthcoming for Falk (as of December 2, 1938). Suddenly, early in 1940, Clague was transferred to the directorship of the Bureau of Employment Security. Falk became Acting Director of the Bureau of Research and Statistics and, after a delay of about 5 months, was made Director on September 15, 1940, at a salary of $8,000. The man who for 4 years had held minor posts and had had a staff of fewer than 30 persons became, overnight, administrative head of a staff of 186 persons. The congressional appropriation at his command jumped from approximately $80,000 to nearly half a million dollars ($484,955 in 1941).[33]

Creation of a Division of Health Studies to draft legislation on compulsory sickness insurance and to produce supporting "research" documents, while obviously consistent with Falk's long-time plans, was inconsistent with the intent of Congress. Back in 1935 Sydenstricker and Falk, while on loan from the Milbank Memorial Fund to the President's Committee on Economic Security, had prepared the report (Risks to Economic Security Arising From Ill Health[34]) which had been the basis for the compulsory health insurance proposals included in the report of the committee to the President on January 15, 1935. The President, however, as noted above, in making his recommendations to Congress on January 17, 1935, stated he would not ask for compulsory health-insurance legislation at that time.

On the same day, as we have already seen, the full-blown economic security bill (63 printed pages), embodying President Roosevelt's recommendations, was introduced by Senator Wagner (S. 1130) and Representative Doughton (H. R. 4120). It contained a section (402) on Duties of the Social Insurance Board, which stated that the Board should have, among its other duties, the "duty of studying * * * health insurance." Such foresight! Here was a bill which the experts had drafted without a compulsory health-insurance title, since the President had expressly, and with good reason, avoided that highly controversial issue—here was a bill so drafted which yet contained a clause that would make it mandatory for the Social Insurance Board to study health insurance and make recommendations to Congress thereon! Congress, be it noted, rewrote that original bill, and Doughton introduced the new bill (H. R. 7260) on April 4, 1935, minus the mandate for the Social Security Board to have the "duty of studying * * * health insurance." The bill, amended, became law on August 14, 1935 (Social Security Act, Public 271).

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[32] Directory of Federal Statistical Agencies, third edition, July 1938, pp. 55–56.

[33] Hearings before subcommittee of Committee on Appropriations, House of Representatives, 76th Cong., 1st sess., Department of Labor-Federal Security Agency bill for 1942, pt. 2, pp. 791–799. See also hearings on Independent Offices appropriation bill for 1938, p. 949. (Falk's staff is now down to 65, budget down to $234,195).

[34] Public Health in the Program for Economic Security, The Milbank Memorial Fund Quarterly, vol. XIII, No. 2, pp. 147–151.

Thus Congress had specifically considered the question of whether or not the Social Security Board was to have a mandate to study health insurance, and had decided in the negative. The language of section 702 of the present law does not, therefore, omit the study of health insurance from the mandatory duties of the Board by oversight but by express intent. However, because Congress failed to strike out the last three words of section 702, namely, "and related matters," which follow the listing of specified subjects which the Board is required to study, Falk has repeatedly stated, and so have various Board representatives, that the Board was authorized to make recommendations with respect to a wide range of subjects (e. g., medicine, medical care, hospital construction, compulsory sickness insurance, etc.) remote from the cash-benefit programs originally constituting the areas of administrative jurisdiction and mandatory research for the Social Security Board.

The question arises whether the Social Security Board (now Administration) has ever had the mandate claimed for it by Falk during the past decade either to study compulsory health insurance or to initiate and draft legislation in that field for Congress. That such a question has arisen in the minds of members of the subcommittee of the House Appropriations Committee which holds hearings on the Federal Security Agency appropriation bill each year is evident from the questions which Representatives Tarver and Keefe have asked again and again about the propriety of the activities of the Bureau of Research and Statistics during the Falk regime. The replies given to the members of the Appropriations Subcommittee have been masterpieces of evasion.[35]

NATIONALIZATION MOVEMENT GAINS STRENGTH

Cradle-to-grave security.—With one of the prime movers for the socialization of medicine firmly established in the Federal Government as Director of the Bureau of Research and Statistics in the powerful Social Security Board and the second ensconced as a consultant to the Director, all was in readiness to put well-matured plans into effect and to initiate a much stronger legislative program than had previously been proposed.

World War II slowed down the plans, but was regarded by some as not without its compensations. While 60,000 physicians were in the armed forces and doctors at home were fully occupied with civilian services the moment would be opportune to sponsor Federal compulsory sickness insurance for the major portion of the population. Hope was expressed that such a program might ride in on the coattails of legislation directed toward general expansion of the entire social security program and provision of special benefits for veterans.

There was talk of cradle-to-grave security. The Beveridge Report on Social Insurance and the Allied Services,[36] published in 1942, carried the promise and threat of legislation for comprehensive social insurance or outright nationalization in Great Britain. New life was instilled into the socializers here and abroad. Opportunists saw in the devastation wrought by war plausible new excuses for saving humanity by bringing entire nations under Government control. There was to be a super New Deal which would bestow universal security based on the principle of "the greatest good for the greatest number— whether they wanted it or not." So fantastic were the dreams of the postwar planners in Great Britain that a Member of Parliament humorously described them as follows:

"Oh, won't it be wonderful after the war?
There won't be no war, and there won't be no pore.
We'll all have a pension about 24,
And we won't have to work if we find it a bore.

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[35] Department of Labor-Federal Security Agency appropriation bill for 1943. Hearings before the subcommittee of the Committee on Appropriations, House of Representatives, 77th Cong., 2d sess., pt. 2, pp. 639, 651–659. See similar hearings year by year.

[36] How real was that threat is shown by the subsequent course of events: the introduction of the national health service bill in Parliament, March 21, 1946; the unfolding of the whole plan to nationalize medicine in Great Britain; and the opposition of the British medical profession which has culminated in a vote by the majority of doctors to follow a noncooperation course. British Doctors Vote Against Cooperation in Present National Health Service Plan, the New York Times, December 13, 1946.

> There won't be no sick and there won't be no sore!
> The beer will be quicker—and better—and more.
> And there's only one road that I'd like to explore—
> Why didn't we have the old wa-er before?" [37]

Expansion of ILO activities during the war.—At the same time that a strong propaganda movement for social security legislation along state Socialist lines was being fomented in the United States, a similar movement was being agitated for the entire Western Hemisphere. In December 1940 at Lima, Peru, in the presence of John G. Winant, past Chairman of the Social Security Board and at that time Director of the ILO, there had been created the Inter-American Committee To Promote Social Security and to lay "the foundations for the future organization of an inter-American conference on social security.[38] About 100 delegates from the Americas were present. Arthur J. Altmeyer, Chairman of the Social Security Board, was the leading delegate from the United States, and during the meetings was made chairman of the provisional committee to act for the 13 member countries.[39] On March 21, 1944, the Secretary of State of the United States notified Mr. Altmeyer that the President had approved his designation as a member of the Permanent Inter-American Committee on Social Security and had designated A. Ford Hinrichs, Acting Commissioner of the Bureau of Labor Statistics, and George St. J. Perrott, Chief of the Division of Public Health Methods in the Public Health Service, as substitutes for Altmeyer.[40]

In January 1945, the governing body of the ILO, of which Carter Goodrich is chairman, decided "to place on the agenda of the Maritime Preparatory Technical Conference the question of seafarers' social insurance, with a view to the formulation of international minimum standards." A special committee, set up by the governing board, met in London July 16–27, 1945, to discuss "a model scheme of seafarers' social security." I. S. Falk, Director, Bureau of Research and Statistics of the Social Security Board, was the "expert" nominated by the United States Government to represent this country at the London Conference.[41] He presented his views on the relation of the scheme for seafarers to the "fundamental principle underlying the existing social insurance system in the United States and all major proposals for its expansion. *This principle is that there should be one basic system covering the entire working population* [emphasis mine] and that any special systems for particular groups should be supplementary to the basic system." [42]

Entering wedge for state socialism proposed.—Returning now to the United States, we find that by 1943 the stage was set for the long-planned, all-out attempt to force through Congress a comprehensive social insurance law. "Now or never!" was the slogan. The social planners were in a position of great strategic importance, being at least inside the Government rather than outside, as they had been before the passage of the Social Security Act. Falk not only had a large research staff, and nearly half a million dollars of the taxpayers' money, including ample travel funds, but he was also in a position to command the aid of technical staffs anywhere in the Federal Government. It amounted to having access to virtually unlimited funds and unlimited staff. Under these auspicious circumstances the first omnibus Wagner-Murray-Dingell bill of 1943 was developed in the Social Security Board.

When Bismarck proposed his comprehensive social insurance program, which was jubilantly hailed as "The highwater mark of German state socialism," the laws were drafted to apply only to persons with low incomes. Sickness insurance in Europe was usually workingman's insurance or poor man's insurance. Indeed, nowhere in the world, save in Russia and New Zealand, had it been proposed to make sickness insurance compulsory for the whole or major portion of the population. It was, then, a revolutionary proposal which was made in 1943 when Senator Wagner boasted that he intended to bring the entire population of 135,000,000 persons under a compulsory sickness insurance scheme which was to be geared into a unified system of national social insurance. "Comprehensive coverage" and "comprehensive benefits" were the propaganda slogans.

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[37] Quoted from the London Chronicle by Edith Abbott in The Beveridge Plan or the American Way, Social Service Review, March 1943, p. 74.

[38] A New Structure for Social Security, ILO, Montreal, 1942, pp. 1–3.

[39] Ibid., p. 31.

[40] Inter-American Committee on Social Security, Provisional Bulletin No. 6, ILO, Montreal, 1944, pp. 4, 5.

[41] Maritime Preparatory Technical Conference, Copenhagen, November 1945, Social Insurance Report VI, ILO, Montreal, 1945, pp. 1–3.

[42] Ibid., p. 52.

When the Wagner-Murray-Dingell bill was introduced on June 3, 1943, a great hue and cry was raised about the alleged power that would be given to the Surgeon General were the bill enacted. However, Falk who drafted the compulsory sickness insurance provisions without consulting the Surgeon General, presumably had no intention of granting any real power to him.[43] In fact, analysis of the bill shows clearly that the power of the Surgeon General was so restricted it would have been impossible for him to make a policy decision, issue any rules and regulations, enter into any agreements, or make any financial commitments without first consulting, and receiving the approval of, the Board of another agency, namely, the Social Security Board. Vested with none of the authority which would normally be given to the administrator of a program of such magnitude, the Surgeon General, had that bill been enacted, would have been merely a puppet doing homage to an all-powerful lay agency. Indeed, the sickness insurance provisions of that bill, together with the relevant administrative and fiscal provisions, were a flagrant grab for power in health and medical matters by the Social Security Board.

Only in those contentious jurisdictions which were well known to be engraved with administrative pitfalls, e. g., appeals procedures, was full and undivided authority conferred upon the Surgeon General. The Social Security Board, which had sponsored the legislation and would be deeply involved in setting up the administrative machinery of the proposed compulsory sickness insurance scheme, washed its hands, so to speak, of responsibility when it came to arbitrament. It is significant of the way in which the 1943 bill was drafted that the Surgeon General could not make an agreement with a doctor, or hospital, or patient without the approval of the Social Security Board; he could not issue rules and regulations except that he do so jointly with the Social Security Board; but, when it came to the appeals procedure he might take full responsibility for all the administrative headaches arising out of a poorly planned program and faulty legislation.

From the point of view of regulative interference and governmental control, the really significant features of the 1943 sickness insurance provisions were: (1) the power conferred on the top policy-making group known as the Federal Advisory Council, the members of which were to be chosen by the Social Security Board and were not to include any statutory representatives of health and medicine, (2) the absence of representation of the medical profession on the board of trustees of the Federal social insurance system, and (3) the vast administrative authority vested in the Social Security Board.

This 1943 proposal to create a unified national social insurance system in the United States, the first bill of its kind to be brought before the Congress, died in committee. Nothing daunted, the Government planners decided to draft an even more grandiose bill to be introduced in the Seventy-ninth Congress. Elaborate plans were worked out behind the scenes. While in 1943 the strategy had called for writing and introducing sickness insurance legislation without consulting the Surgeon General, in 1944 he was not only consulted but was even induced to get on the Wagner-Murray-Dingell bill bandwagon. In order to make it appear that the Public Health Service was solidly back of the Social Security Board plan to insist on distributing the cost of medical care services by means of the social insurance principle, the Federal Security Administrator advised the Public Health Service to cooperate with the Social Security Board in drafting legislative proposals. In October 1944 the staffs of Falk and Perrott, under Falk's supervision, began to work on the nursing and dental provisions of the new version of the Wagner-Murray-Dingell bill which was then being drafted preparatory to introduction in 1945.

PUBLIC AND PRIVATE LOBBYING ACTIVITIES INTEGRATED

Interested officials initiate ostensibly disinterested statements.—Since the effectiveness of propaganda depends upon the integration of activities on many fronts so that all are perfectly timed to influence the masses, organization of committees and conferences necessary to mold public opinion was begun 2 years in advance of the introduction of the 1945 Wagner-Murray-Dingell bills. Late in 1943, Davis organized the health program conference which ultimately produced the report on Principles of a Nation-wide Health Program. This report was published by the Committee on Research in Medical Economics which Davis had organized in 1936 with a grant of $165,000 from the Rosenwald Fund.[44] Timed to appear shortly before the Seventy-ninth Congress convened in January 1945, this conference report, we may infer, was designed to produce the desired climate of opinion. On May 24, 1945, S. 1050, the new version of the 1943 Wagner-Murray-Dingell bill was introduced by Senator Wagner for himself and Senator Murray and was referred to the Finance Committee of the Senate which failed to call for hearings. Then, in a clever move to obtain public hearings on the compulsory sickness insurance provisions of the over-all plan for comprehensive national social insurance, Wagner and Murray introduced S. 1606 on November 19, 1945. That same day, President Truman announced his broad program of social legislation which included compulsory sickness insurance as one of the goals of the administration. Since S. 1606 omitted the taxing provisions and confined itself to health and medical provisions, it was referred to the Education and Labor Committee where it was assured of favorable consideration since Senator Murray himself was the chairman.

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[43] Falk and his staff drafted two compulsory sickness insurance bills in 1943; one, designated the "A. F. of L. bill," was eventually introduced by Senator Wagner on June 3, 1943. The other, known to members of Falk's staff os "our bill," i. e., the Social Security Board bill, was used by Falk to make Surgeon General Parran think he was being consulted about the proposed Federal legislation. In reality, Dr. Parran was kept in the dark about the contents of S. 1161 (78th Cong.) because the Social Security Board planners thought it would be good strategy not to let him know what was being proposed. The Board submitted to Dr. Parran only 4 of the 17 major sections of S. 1161, or the equivalent of 34 of the 90 printed pages of the bill. Parts of the 4 sections were seductively worded to appeal to PHS, but such wording was not included in S. 1161.

Bureaucrats draft "Principles of a Nation-wide Health Program"

When Senator Wagner introduced the national health bill of 1945 he quoted in extenso from the "Principles of a Nation-wide Health Program" without, however, identifying the authors or indicating the tie-in with the Federal official who had written the major portion of S. 1606.[45] Senator Wagner, in referring to this conference report, stated that it had been issued by "29 leading health experts, including 13 outstanding doctors." What he failed to state was that 7 of the 29 hand-picked conferees were Federal officials who might reasonably expect to obtain lucrative and powerful positions in the Government insurance system which they were advocating. The 7 conferees who were Federal employees at the time the report was prepared were:

Isidore S. Falk, Director, Bureau of Research and Statistics, Social Security Board.

George St. J. Perrott, Chief, Division of Public Health Methods, USPHS, and official liaison between Parran and Altmeyer.

Dean A. Clark, M. D., USPHS, now on loan as Director of the Health Insurance Plan for Greater New York.

Frederick D. Mott, M. D., former reserve officer of the USPHS, on loan to the Farm Security Administration, now Chairman, Health Services Planning Commission, Department Public Health, Saskatchewan, Canada.

Barkev S. Sanders, statistician, Chief of Health Studies on Falk's staff, SSB.

Kenneth E. Pohlmann, labor organizer, on Dr. Mott's staff, Department of Agriculture, and

William Haber, professor of economics, University of Michigan, formerly with National Resources Board, later with War Manpower Commission.

Senator Wagner likewise failed to state that four of the country's "leading health experts" who were responsible for the conference report were members of the National Citizen's Political Action Committee, the fund-raising committee for the CIO-PAC of which the late Sidney Hillman of the CIO was chairman. Those four NCPAC members were Will W. Alexander, vice president of the Julius Rosenwald Fund and formerly Administrator of the Farm Security Administration; Ernst P. Boas, M. D., chairman of the Physicians Forum; Michael M. Davis, chairman of the Committee on Research in Medical Economics and later chairman of the Committee for the Nation's Health; and J. Raymond Walsh, research director of the CIO.[46] Senator Wagner further failed to state that

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[44] Julius Rosenwald Fund, Eight Years' Work in Medical Economics, 1929–36, p. 25.

[45] Principles of a Nation-Wide Health Program, Report of the Health Program Conference, published through cooperation of the Committee on Research in Medical Economics, New York, November 1944, 34 pp. See Senator Wagner's speech, Congressional Record, vol. 91, pp. 10789–10795, November 19, 1945, including statement that bill was "all-inclusive" and that plan "would take in everybody," ibid., p. 10795. A. J. Altmeyer, then Chairman of Social Security Board, later testified that I. S. Falk "did a major or considerable part" in preparing S. 1606 "in cooperation with the United States Public Health Service and others." Hearings, National Health Program, loc. cit., pt. 1, p. 191.

[46] National Health Program, hearings before the Committee on Education and Labor, United States Senate, 79th Cong., 2d sess., on S. 1606, pt. 5, p. 2705.

UNITED STATES

REPRESENT
Biemiller
Dingell

SENATORS
Wagner
Murray
Pepper

CONGRESSIONAL C

HOUSE WAYS AND
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cluded John J. Cc
rector, Washingtc
Bureau Dir. in Sc

SENATE BANKING ANI
WAGNER, Cha

SENATE EDUCATION
MURRAY, Chai
PEPPER
Bertram M. Gross
RFC by Watson B.
liaison with F A
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and Harry Ros
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Carl Malmberg
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Dean Clark, M.D.
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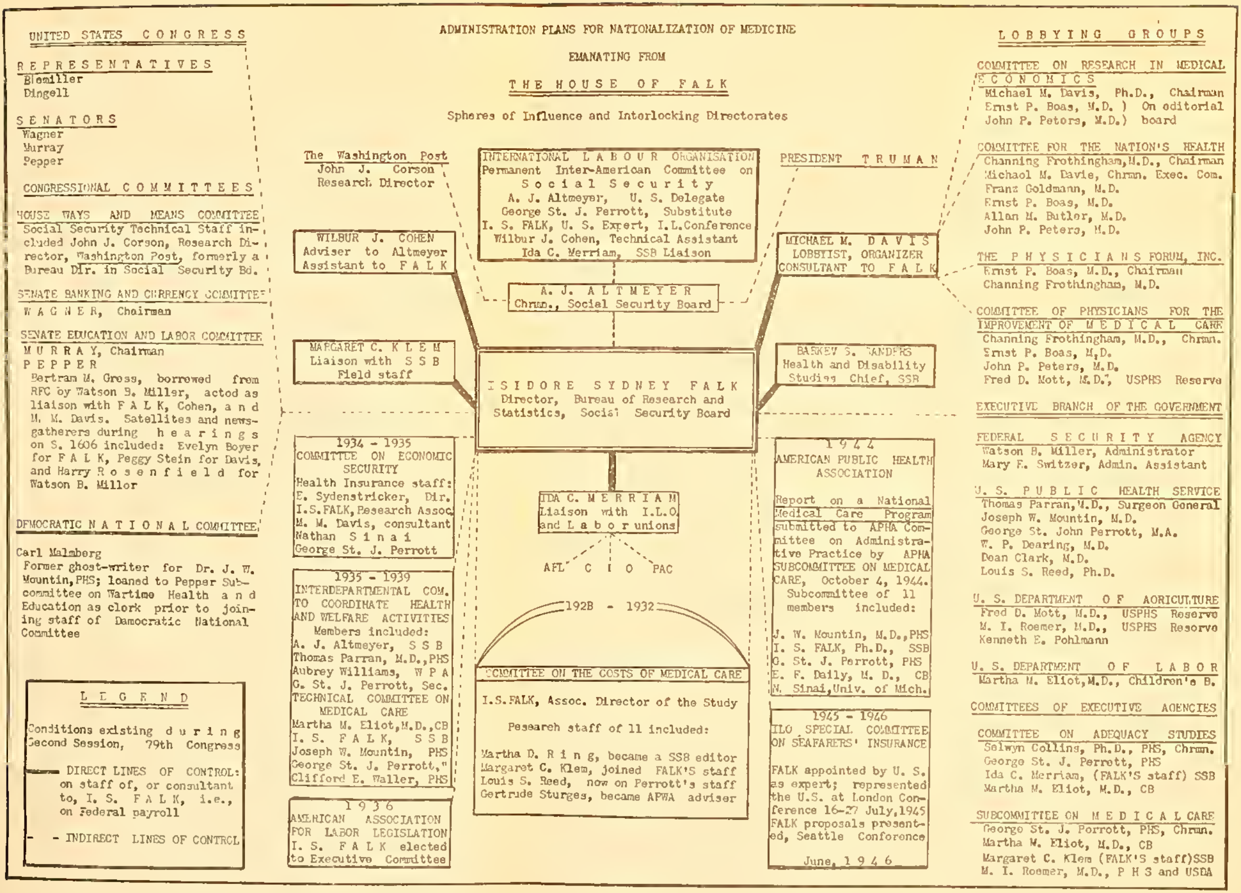

ADMINISTRATION PLANS FOR NATIONALIZATION OF MEDICINE

EMANATING FROM

THE HOUSE OF FALK

Spheres of Influence and Interlocking Directorates

UNITED STATES CONGRESS

REPRESENTATIVES

Biemiller
Dingell

SENATORS

Wagner
Murray
Pepper

CONGRESSIONAL COMMITTEES

HOUSE WAYS AND MEANS COMMITTEE

Social Security Technical Staff included John J. Corson, Research Director, Washington Post, formerly a Bureau Dir. in Social Security Bd.

SENATE BANKING AND CURRENCY COMMITTEE

WAGNER, Chairman

SENATE EDUCATION AND LABOR COMMITTEE

MURRAY, Chairman
PEPPER

Bertram M. Gross, borrowed from RFC by Watson B. Miller, acted as liaison with FALK, Cohen, and M. M. Davis. Satellites and newsgatherers during hearings on S. 1606 included: Evelyn Boyer for FALK, Peggy Stein for Davis, and Harry Rosenfield for Watson B. Millor

DEMOCRATIC NATIONAL COMMITTEE

Carl Malmberg
Former ghost-writer for Dr. J. W. Mountin, PHS; loaned to Pepper Subcommittee on Wartime Health and Education as clerk prior to joining staff of Democratic National Committee

LEGEND

Conditions existing during Second Session, 79th Congress

━━ DIRECT LINES OF CONTROL: on staff of, or consultant to, I. S. FALK, i.e., on Federal payroll

- - INDIRECT LINES OF CONTROL

The Washington Post
John J. Corson
Research Director

WILBUR J. COHEN
Adviser to Altmeyer
Assistant to FALK

MARGARET C. KLEM
Liaison with SSB
Field staff

INTERNATIONAL LABOUR ORGANISATION
Permanent Inter-American Committee on Social Security
A. J. Altmeyer, U. S. Delegate
George St. J. Perrott, Substitute
I. S. FALK, U. S. Expert, I.L.Conference
Wilbur J. Cohen, Technical Assistant
Ida C. Merriam, SSB Liaison

A. J. ALTMEYER
Chmn., Social Security Board

PRESIDENT TRUMAN

MICHAEL M. DAVIS
LOBBYIST, ORGANIZER
CONSULTANT TO FALK

BARKEV S. SANDERS
Health and Disability Studies Chief, SSB

ISIDORE SYDNEY FALK
Director, Bureau of Research and Statistics, Social Security Board

IDA C. MERRIAM
Liaison with I.L.O. and Labor unions

AFL
CIO
PAC

1934 - 1935
COMMITTEE ON ECONOMIC SECURITY
Health Insurance staff:
E. Sydenstricker, Dir.
I.S.FALK, Research Assoc.
M. M. Davis, consultant
Nathan Sinai
George St. J. Perrott

1935 - 1939
INTERDEPARTMENTAL COM. TO COORDINATE HEALTH AND WELFARE ACTIVITIES
Members included:
A. J. Altmeyer, SSB
Thomas Parran, M.D., PHS
Aubrey Williams, WPA
G. St. J. Perrott, Sec.
TECHNICAL COMMITTEE ON MEDICAL CARE
Martha M. Eliot, M.D., CB
I. S. FALK, SSB
Joseph W. Mountin, PHS
George St. J. Perrott, "
Clifford E. Waller, PHS

1936
AMERICAN ASSOCIATION FOR LABOR LEGISLATION
I. S. FALK elected to Executive Committee

192B - 1932
COMMITTEE ON THE COSTS OF MEDICAL CARE

I.S.FALK, Assoc. Director of the Study

Research staff of 11 included:

Martha D. Ring, became a SSB editor
Margaret C. Klem, joined FALK'S staff
Louis S. Reed, now on Perrott's staff
Gertrude Sturges, became APWA adviser

1944
AMERICAN PUBLIC HEALTH ASSOCIATION

Report on a National Medical Care Program submitted to APHA Committee on Administrative Practice by APHA SUBCOMMITTEE ON MEDICAL CARE, October 4, 1944. Subcommittee of 11 members included:

J. W. Mountin, M.D., PHS
I. S. FALK, Ph.D., SSB
G. St. J. Perrott, PHS
E. F. Daily, M. D., CB
N. Sinai, Univ. of Mich.

1945 - 1946
ILO SPECIAL COMMITTEE ON SEAFARERS' INSURANCE

FALK appointed by U. S. as expert; represented the U.S. at London Conference 16-27 July, 1945
FALK proposals presented, Seattle Conference

June, 1946

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M. I. Roemer, M.D., PHS and USDA

two of the conferees, Alan Gregg, M. D., director of medical services at the Rockefeller Foundation, and Will W. Alexander, were associated with foundations long active in the movement to socialize medicine and for many years contributors to the work of Falk and Davis in this direction. Nor was mention made of the fact that Dr. Boas was a member of at least eight Communist-front organizations.

Senator Wagner did not disclose the tie-in of many of the "leading health experts" with the Falk clique. Thus one of the conferees was Gerald Morgan who had been appointed by Falk on March 21, 1939, as a disability insurance consultant for the Division of Health Studies in the Social Security Board. This appointment had been prompted by the fact that Mr. Morgan lived at Hyde Park, was a neighbor of the late President, and in 1922 had published a book, "Public Relief of Sickness," which was not inconsistent with some of Falk's views about the separation of cash and medical sickness benefits.

Senator Wagner failed to state that the majority of the "13 outstanding doctors" who signed the conference report were not practicing physicians, but were salaried employees of the Government or staff members of universities or research institutions. For instance, one of the conferees was Franz Goldmann, associate clinical professor of public health at Yale University, who was born and educated in Germany and who had never practiced medicine in this country. Dr. Goldmann had been affiliated with the city health department of Berlin from 1922 to 1929 and with the Department of the Interior of the German National Government from 1929 to 1933. He later worked with the Health Section of the League of Nations. In 1928 he wrote a volume on German sickness insurance benefits for the ILO and in 1945 published a book on "Public Medical Care."[47] Nine years ago he joined the Yale faculty, according to his testimony at the Senate hearings on S. 1606.[48] He has served as consultant to the Social Security Board and the Department of Agriculture in connection with plans for distribution of medical care services. Finally, Senator Wagner failed to point out that the publication of this document which he quoted in support of the principles of S. 1606 was financed and managed by Davis' committee on research in medical economics which in turn had been financed by the Rosenwald Fund and the Rockefeller Foundation. It is small wonder that these 29 carefully selected conferees produced a document favoring compulsory sickness insurance under Federal control!

Shrewd manipulation of platform of APHA

A second supporting document referred to by Senator Wagner was the policy statement on "Medical Care in a National Health Program" which had been adopted in October 1944 by the American Public Health Association. Perhaps the Senator did not know that the platform of the American Public Health Association had been written the Falk-Davis way after much behind-the-scenes manipulation during the summer of 1944 at the Social Security Board and the United States Public Health Service. Then, as Joseph W. Mountin, M. D., of the Public Health Service, chairman of the medical care subcommittee, boasted, the platform had been "rammed down the throats" of the subcommittee and later of the full committee on administrative practice of the APHA. A thoughtful analysis of the platform and of the way in which its adoption was engineered was written by Dr. W. G. Smillie of Cornell University Medical School.[49] He points out that the platform was adopted without ample time for "assimilation and analysis."

An editorial in the Journal of the American Medical Association, published after the adoption of the APHA platform, likewise pointed out that the statement had not been submitted to the full membership of the APHA for a vote. The association at that time had 7,493 members, including 1,571 fellows. "The report on compulsory health insurance represents, therefore, the action of the subcommittee [of 13] which prepared it, the committee on administrative practice [of 17] which approved it and the 49 members of the governing council who voted in its favor. *Here is not a democratic practice in action; here is a shrewdly manipulated performance by full-time public officials, economists, bureaucrats.* [Emphasis mine.] Most of the names of those on the subcommittee are those men long committed to Federal compulsory sickness insurance and to Federal control of all matters in the health field. * * * The rejection by the majority group of the proposal for consultation with medical and dental leaders indicates the attitude that may be expected of them if they should have control of the Washington bureaucracy that would dominate American medicine should their ideas become effective. Perhaps this step in which these men had leadership will be useful in serving notice once more on the medical, dental, nursing, pharmaceutical and other professional groups as to the nature of the political manipulators in the fields of social security and public health whom the medical professions will be forced to combat." [50] Members of the APHA subcommittee whose names have long been associated with the socialization movement were: Joseph W. Mountin, chairman; I. S. Falk, George St. J. Perrott, and N. Sinai.

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[47] Goldmann, Franz, and Grotjahn, Alfred: Benefits of the German Sickness Insurance System From the Point of View of Social Hygiene, Geneva, 1928; Goldmann, Franz, Public Medical Care, New York, 1945, 226 pp.

[48] National Health Program, loc. cit., pt. 4, pp. 2218–2221.

[49] Smillie, W. G., M. D., An Appraisal of a National Program for Medical Care, American Journal of Public Health, vol. 35, pp. 587–592, p. 590, June 1945.

This APHA platform, it will be recalled, set forth the following principles, namely, (1) A single responsible agency is a fundamental requisite to effective administration of the plan at all levels: Federal, State, and local; (2) the services should be financed on a Nation-wide basis; and (3) adequate support for the plan is to be secured "through social insurance, supplemented by general taxation or by general taxation alone." As Professor Smillie has pointed out:

"The Federal Government, with some State participation, collects and distributes the funds for the medical services for the Nation as a whole. This is accomplished by a tremendous bureaucratic machine which coordinates all medical services of whatever nature in every community in the land down to the last physician, nurse, local hospital, and local health center. All public health activities, as well as all medical and hospital services, will be under the direct administration of a single responsible agency.' " [51]

That single responsible agency would be, to all intents and purposes, the Social Security Administration which has already assumed leadership in planning the program, drafting the legislation, and stating how the program would be operated.

Outlets for propaganda for the masses.—It is evident there now exists in this country a small clique which operates a well-organized propaganda machine for promoting compulsory sickness insurance legislation. Governmental and nongovernmental units are closely integrated through interlocking committee memberships and interchangeable chairmanships. When sickness insurance legislation is to be introduced in Congress officials inside the executive branch of the Government write the bills and supervise preparation of supporting "research" reports to "explain" and "justify" the legislation. Outside lobbies handle the ostensibly disinterested "educational" work. Bills are timed to appear on the same day as a Presidential message, thereby attaining greater newspaper publicity. Shortly before and immediately after the bills are introduced in Congress a veritable broadside of articles appears in official and unofficial media directly or indirectly controlled, or strongly influenced, by the very officials responsible for the legislation. Witness articles in the Social Security Bulletin, the Survey Graphic, the American Labor Legislation Review, the Milbank Memorial Fund Quarterly, to mention a few. The staff of the Physicians Forum, Inc., wrote articles which were circulated to organized labor, social workers, students, and other groups late in 1945 in connection with the W-M-D bills. Such articles, based on "factual" material stemming from a single Federal source, "favor the objectives" of the legislation and chant the slogans furnished by the Federal clique. Private gifts are solicited to make possible the wide distribution of hundreds of thousands of these inspired articles. The material is highly colored, sometimes inaccurate, and often deliberately misinformative. A few of the outlets may be mentioned to illustrate how propaganda for nationalization of medicine is disseminated and public opinion subtly molded.

Committee for the Nation's Health, Inc.

At the hearings on S. 1606 Michael M. Davis testified that his activities were "educational" not promotional,[52] but on September 29, 1946, it was reported by the Evening Star that Joseph H. Louchheim, New York City, had registered with the Clerk of the House under the Reorganization Act as a lobbyist for the Committee for the Nation's Health, Inc. Davis is chairman of the executive committee of the Committee for the Nation's Health, Inc., which, now that the law has caught up with it, is admitted to be a lobbying group. During the hearings on S. 1606 it opened Washington offices, in addition to its New York headquarters, in order to handle newspaper publicity and other promotional work.

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[50] American Public Health Insurance Declaration, Journal American Medical Association, vol. 126, No. 7, pp. 434, 435, October 14, 1944.

[51] Smillie, loc. cit., p. 590.

[52] National Health Program, hearings on S. 1606, loc. cit., pp. 2702–2703.

The Physicians Forum, Inc.

A small but vocal group of about 1,000 physicians, incorporated as the Physicians Forum, has served as an outlet for compulsory sickness insurance propaganda. While it claims to have a Nation-wide membership, its chairman admitted that about two-thirds of the members are in New York State. During the year 1945–46 this organization distributed 125,000 copies of pamphlets, leaflets, etc. The activity of the Forum has been largely concentrated on the W-M-D bills. During the period July 1, 1945, to May 31, 1946, the Forum expended over $25,000, including a special W-M-D grant of $11,500. .Dr. Ernst P. Boas is chairman; Federal employee Milton I. Roemer, M. D., a member of Dr. Mountin's staff at the Public Health Service, is a council member of the Forum and active W-M-D lobbyist[53]; Peggy Stein, long associated with Michael M. Davis, is a member of the Washington chapter of the Physicians Forum as well as the Washington representative of the Committee for the Nation's Health, Inc.

Leslie A. Falk, M. D.,[54] who during the war served on loan from the War Department as the chief investigator on the staff of the Pepper Subcommittee on War time Health and Education of the Senate Education and Labor Committee, is another council member of the Physicians Forum, Inc.[55] Dr. Falk, whose name appears on the staff which prepared the health insurance report for Senator Pepper,[56] has had his appointment to the Commissioned Corps of the Public Health Service confirmed by the Senate.

Senate committees

While the Seventy-ninth Congress was in session, nonmedical officials in the Federal Security Agency were particularly active in advising Senate committees with respect to health and medical matters and in preparing reports which were issued as Senate Education and Labor Committee prints. Propaganda prepared by nongovernmental lobbying groups under the direction of Federal officials was inserted in Senate reports, thereby attaining an aura of authority and congressional sanction which they scarcely merited. Thus, both the report of the health program conference and the APHA platform were cited not only by Senator Wagner when he introduced S. 1606 on November 19, 1945, but also in Senate committee print No. 1, entitled "National Health Act of 1945," transmitted on November 26, 1945, and printed in 1946. This was a "Report to the Committee on Education and Labor"—To not From the committee. The average citizen. I dare say, would have no way of knowing that both these documents which were cited as supporting the principles incorporated in the Wagner-Murray-Dingell bill, S. 1606, had been written under the direction of the Falk-Davis ring and were part of the over-all plan to "sell" State Socialist compulsory sickness insurance legislation to Congress and to the public at large. The average citizen would not know that the document submitted to the Education and Labor Committee of the United States Senate had been printed without ever having been discussed by the committee or without a vote of approval by that committee.

During the 2 months when the Hill-Burton hospital construction bill was being discussed in the executive sessions of the Committee on Education and Labor, it was I. S. Falk who sat at Senator Murray's right hand as consultant in this field; it was he who produced statistical tables on the formulae to be used in distributing hospital construction funds; it was he, and not the representative of the Public Health Service, who assumed active leadership in discussing administration and financing of the hospital construction program. And after the bill had been enacted, Falk's right-hand man and consultant, Michael M. Davis, was named a consultant on the Federal hospital advisory council. Later, when S. 1606 was under consideration, it was the Bureau of Research and Statistics, headed by Falk, that furnished one document after another showing the "need" for compulsory sickness insurance, the "need" for Government intervention, and the way in which the proposed scheme would operate.[57]

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[53] War Doctors' Worries Discussed at Meeting of Physicians' Forum, the Evening Star, June 7, 1946. Speakers from Public Health Service at meeting: Palmer Dearing, M. D., and M. I. Roemer, M. D.

[54] Not known to be related to I. S. Falk.

[55] Minutes of Annual Membership of the Physicians Forum, Inc., June 19, 1946, pp. 1, 5.

[56] Health Insurance, subcommittee Rept. No. 5, 79th Cong., 1st sess., issued in March and July 1946, by subcommittee on health and education of the Committee on Education and Labor. For the story of the release of this report and of newspaper releases favoring health insurance, see Congressional Record, July 23, 1946, pp. 9841–9847, and July 24, 1946, pp. 10047–10050.

[57] National Health Act of 1945, Report to the Committee on Education and Labor: Senate Committee Print No. 2, 1945, 79th Cong., 2d sess.; Medical Care Insurance a Social Insurance Program for Personal Health Services, report from the Bureau of Research and Statistics Social Security Board to the Committee on Education and Labor, United States Senate, July 8, 1946, 186 pp., Senate Committee Print No. 5, 79th Cong., 2d sess.

War Department

Two of the educational manuals issued by the War Department for the use of personnel of the Army, Navy, Marine Corps, and Coast Guard here and overseas contained one-sided statements favoring Government-controlled sickness insurance.[58] In Manual 763 appears the familiar shibolleth "Health insurance * * * must be compulsory."[59] In EM 29 GI Roundtable entitled "Is Your Health the Nation's Business," the APHA platform and the Health Conference Report were quoted at length without their true identity, authorship, and propaganda purpose being revealed. Manual 763 was withdrawn because of public protest over the economic theories therein espoused; EM 29 is still in circulation.

The latter was prepared for the United States armed forces as an educational document by the Government-financed *ad hoc* Historical Service Board of the American Historical Association. Cleverly and plausibly worded, EM 29 relied heavily on the Falk-Davis Report of the hand-picked Health Program Conference and on the Falk-Mountin-Perrott engineered platform of the APHA. Published in 1946 before hearings had been held on the W-M-D proposals, EM 29 contains a strong build-up for compulsory insurance and the bills then pending in Congress, while ignoring other approaches and other national health legislation. Statements throughout the pamphlet are misleading, as e. g., those on selective service rejections, distribution of hospital facilities, provisions of the W-M-D bills, to mention a few. The reader is supposed to be impressed by the happy coincidence of the APHA and the health conference recommendations with the provisions of the W-M-D bills. But the reader is not informed that the authors of the much-quoted "research" reports include the author of the W-M-D bills. Nor is the reader informed that the little group of nonmedical Government officials who are seeking control of the five-to-seven-billion-dollar health and medical fund which it is hoped will accrue from annual tax collections if the W-M-D type of legislation is enacted is the same little group that has consistently put forth shrewdly manipulated statistics on the need for a federally controlled medical care program. It is not intended to imply that the War Department was cognizant of these facts, merely that it, like other agencies, was used as a "front."

SUMMARY AND CONCLUSIONS

Blueprint calls for ultimate nationalization of medicine.—Dr. Boas has referred to S. 1050 as the "blueprint." Insofar as principles concerning the method of distributing medical care services is concerned, the blueprint is to be found in the 1927 ILO recommendations and in later proposals made by that Organization, especially the 111 principles presented at the International Labour Conference in Philadelphia in 1944. The ILO recommended that member nations apply these principles "as rapidly as national conditions allow, in developing their medical care services" and that they report to the ILO "concerning the measures taken to give effect thereto."[60] Our most important social legislation, it would seem, is to be based on principles representing the consensus of opinion of the representatives of the socialist countries of Europe and of numerous other countries whose social and economic conditions are dissimilar from our own.

The nationalizers, having the blueprint in mind, move forward step by step, according to plan. Isolated advances are made, sometimes on seemingly unrelated fronts, as one small piece of legislation after another is enacted. High pressure tactics are employed in Congress. Committees, as instruments for social action, are manipulated adroitly both inside and outside the Federal Government. "Crisis" psychology is invoked. The need for Government intervention is maximized, costs of programs are minimized. Under the guise of urgency, measures are jammed through committees as was done in the case of the platform of the American Public Health Association and as was attempted with the maternal and child health bill (S. 1318, 79th Cong.). Bills are slyly introduced into Congress at propitious moments and are then cleverly brought to a vote without adequate hearings and without public knowledge of what is afoot. Thus by stealth was this Nation maneuvered into the ILO without referral of the matter to the people. Thus by stealth and adroit maneuvering might we be jockied into acceptance of a national compulsory sickness insurance scheme because the true meaning of the legislation would be concealed from the people and even from the Members of Congress.

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[58] Economics: Principles and Problems, Education Manual EM 763, March 30, 1944, p. 482, and Is Your Health the Nation's Business? EM 29 Roundtable, January 16, 1946.

[59] EM 763, loc. cit., p. 482.

[60] Social Security: Principles and Problems Arising Out of the War, ILO, Montreal, 1944, Report IV (1), pp. 102–115.

United States already committed to Socialist program.—By virtue of our membership in the ILO and of our representation on the Permanent Inter-American Conference on Social Security, this country is committed to a national policy in favor of enactment of Federal legislation that would impose upon the entire population a comprehensive national social-insurance program including compulsory sickness insurance. Plans for socialization of medicine now call for nationalization rather than for State action which was the goal in 1939 and earlier. It is to be remembered that an enlightened, alert Congress is all that stands between us and the program of State socialism which has already been adopted in more than 30 countries under the aegis of the ILO and which our official ILO representatives have pledged themselves to support.

Nationalization advocated by officials who would administer laws.—The nationalization movement is not a spontaneous upsurgence from the people. Instead, it has been skillfully planned and engineered by a handful of nonmedical men who would greatly benefit if their schemes were realized. The leader of the movement is I. S. Falk whose coworkers and supporters are: M. M. Davis, A. J. Altmeyer, G. St. J. Perrott, W. J. Cohen, and N. Sinai. Members of the medical profession who actively support the movement or naively serve as a "front" for political activities they have not fully fathomed are: Ernst P. Boas, John P. Peters, Channing Frothingham, Allan Butler, and a few others. Official backing has been, or is now, provided by such past or present Cabinet officers or other high officials as: the late President Roosevelt, President Truman, Frances Perkins, the late Harry Hopkins, Aubrey Williams, and Henry Wallace. The leaders, rather than members of the legislative branch of the the Government draft the social insurance bills. It is these same leaders and promoters who would administer the multi-billion-dollar programs they advocate so eloquently.

Over the past two decades there has been developed an efficient propaganda machine for the purpose of "educating" Congress and the masses. The operators of the machine work not only outside, but also inside the Government, notwithstanding the fact that there is a Federal law against such lobbying activities on the part of Federal employees.[61] Congressional appropriations have been used to carry on promotional work inside the Government in favor of particular types of Federal social insurance, despite the fact that it was the clear intent of Congress that the Social Security Board should not study health insurance. Funds of foundations and of private philanthropists have been used for lobbying activities outside the Government. All branches of the propaganda work have been integrated by the leaders of the nationalization movement who have moved into the Government since 1933.

State socialism implicit in comprehensive social insurance scheme.—A backward glance over the past 20 years will show how much has already been accomplished in making the blueprint for nationalization a reality. And the question naturally arises whether one can use the tools, devices, and social programs of the Socialist state without eventually having such a state In an analysis of capitalism, socialism, communism, and other economic systems, made in 1938 before any of these comprehensive social-insurance schemes had come to the surface in this country, the economists Loucks and Hoot pointed out that:[62]

"Every Socialist program advocates a comprehensive scheme of social insurance, in the interest of economic security for the individual. * * *

"Without denying that systems of social insurance might be established and operated successfully under an economy essentially capitalistic in nature, the Socialist argues that the efficient operation of a comprehensive scheme of social insurance is possible only under socialism. Only under the centralized and planned control exercised by such a system could the necessary coordination be developed among wages, contributions, and benefits, between the payment of benefits and the offering of opportunities to work, and among the various forms of benefits. Moreover, the Socialist contends that the cost of protecting the individual against the uncertainties of income which lie outside his control should be borne by society as a whole, in the manner least costly to the group as a whole. To distribute the costs in this manner requires a fusing of incomes and accounts held to be impossible under a capitalistic economic system. *For these reasons, all modern socialistic programs advocate schemes of social insurance.* * * *" [Emphasis mine.]

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[61] Title 18, sec. 201, United States Code. See appendix C.

[62] Loucks, William N., and Hoot, J. Weldon, Comparative Economic Systems, 1938, p. 347

It is not far-fetched to think that if the United States were to adopt a social program which could only achieve its most efficient form of operation under socialism, pressure would be brought to bear to bring about such efficiency through a change in our form of government. All of Europe which adopted the Bismarckian social insurance laws has finally moved further and further toward the left. Laws, which in the beginning gave limited power over the individual, have been amended to give more and more power, until many countries have wound up with full dictatorships. Compulsory insurance laws have been enacted over great opposition in other countries, but they have been enacted.

Well-organized, persistent minorities have prevailed in engineering this world trend toward socialism. They are actively at work in our own country. Their leaders have penetrated the executive branch of the Federal Government and even now bore from within, seeking stealthily to extend their power to the legislative branch. Will the United States, under the guidance of leaders imbued with alien ideologies, be sucked into this international movement? Will we accept Bismarck's blueprint for state socialism as we accepted membership in the International Labour Organisation, blindly, without understanding, and without free and open discussion of the issues at stake?

It took 50 years to transform Bismarck's Reich into Hitler's Führerstaat—50 years of compulsion, regulative interference, and the indoctrination of new generations.[63] It took Great Britain 35 years (1911–46) to move from enactment of her basic compulsory sickness insurance law to the current proposals to nationalize medicine. Government control of medicine has proved to be a prelude to, or concomitant of, Government control of utilities, coal mines, industry in general, land, and finally of the people themselves. The part played by comprehensive social insurance laws in bringing about these transformations has not been fully brought to view. Be it remembered, compulsory sickness insurance laws are a political and bureaucratic device for attainment of power over people and exchequers; they have little to do with health. In their enactment, labor has been sold down the river to the tune of small bribes, large taxes, and poor medicine, while the health and medical professions have almost invariably been double-crossed. The planners who make the blueprint, draft the legislation, and operate the propaganda machines are generally to be observed working for personal gain rather than in the public interest.

The full social and economic impact of the proposed comprehensive national social insurance scheme would not be felt immediately. The price would not be paid in a day, or a year, or a decade. But ultimately—a generation, possibly two generations, hence—the price would be paid in loss of freedom and in the production of a Nation of weaklings who, content with a minimum of subsistence from a paternalistic government, would no longer seek a maximum of living from their endeavors.

APPENDIX A

WHO'S WHO IN THE NATIONALIZATION MOVEMENT[64]

Falk, Isidore Sydney: Born Brooklyn, 1899; son of Samsin and Rose (Stolzberg) Falk. Ph. D. Yale, 1923, bacteriology. On faculty, University of Chicago, 1923–29; director of surveys, Chicago Department Health, 1925–27; resigned both positions under fire. In December 1929 Falk (1) was alleged to have made unwarranted claims about isolation of "flu" germ; (2) left University of Chicago; and (3) joined staff of Committee on the Costs of Medical Care. Associate Director of Research, CCMC, 1929–33; Research Association, Milbank Memorial Fund, 1933–36. Went to Social Security Board in 1936 as principal medical economist in Division of Planning and Analysis in the Bureau of Research and Statistics; was made Chief of Division of Health Studies at $6,400, August 3, 1937; in 1938 given title of Acting Assistant Director, Bureau of Research and Statistics; promoted to Assistant Director at $6,500, November 7, 1938; salary increase to $7,000, December 2, 1938; promoted to Director, Bureau of Research and Statistics, September 15, 1940, $8,000; holds same position at $10,000.

Falk provides the leadership for the nationalization movement; integrates lobbying activities inside and outside Government; drafts compulsory sickness insurance legislation or supervises drafting; manipulates committee findings;

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[63] Marx, Fritz M., Government in the Third Reich, New York, 1937, pp. 1–14, 53–87.

[64] Listed in order of approximate relative importance with respect to activity and influence. Omitted are: (1) Names of certain Cabinet officers, and (2) names of physicians used as "fronts" but not otherwise active as lobbyists.

serves as consultant to certain Members of Congress; writes reports for Education and Labor Committee favoring the principles of the Federal legislation he has drafted. His administration was thoroughly investigated by the House Ramspeck Committee and a report was prepared under date of March 24, 1944. Two other congressional committees have investigated Falk's record because of numerous complaints of alleged maladministration made by staff members who resigned in protest and because of complaints from sources outside the Government that Falk and members of his staff and other Federal employees under his influence have engaged in lobbying despite the Federal law which prohibits such activities (title 18, sec. 201, U. S. Code).

Davis, Michael M.: Born New York City, 1879, Ph. D. Columbia, 1906. Director Boston Dispensary, 1910–20; secretary, Committee on Dispensary Development, New York City, 1920–27; director, medical services, Rosenwald Fund, Chicago, 1928–36; chairman, Committee on Research in Medical Economics, Inc., since 1937 (committee supported by grants from Rosenwald Fund, Rockefeller Foundation, and Albert Lasker). Appointed January 28, 1938, as principal consultant in medical economics, Health Studies Division, Social Security Board, under Falk, at $18.05 a day, with all expenses for not to exceed 200 days in the fiscal year; appointed consultant Federal hospital council 1946. One of organizers of CCMC and of Committee for the Nation's Health, Inc. Chairman, Executive Committee of Committee for Nation's Health, Inc. Office: 1790 Broadway, New York City; office Committee for Nation's Health, Inc., 402 Sixth Street NW., Washington, D. C. Organizer, lobbyist, pamphleteer; liberally financed by foundations and private philanthropists; works closely with Falk, Parran, and Perrott.

Altmeyer, Arthur J., Ph. D.: Labor economist. Assistant Administrator, Federal Security Agency, and Commissioner of Social Security, formerly Chairman Social Security Board. Appointed to Social Security Board August 1935; became Chairman of Board in 1937; appointment renewed for 6 years by President, August 1945. Has been "educated" by Falk in sickness insurance field. Backs Falk to limit and is chief source of Falk's power. Serves as sounding board for Falk's proposals to Congress, International Labor Organization, organized labor in this country, social workers, and other groups. Appointment by the President as member of Social Commission of the Economic and Social Council, United Nations Organization, confirmed by Senate, January 17, 1947.

Parran, Thomas, M. D.: Surgeon General USPHS. Has been associated with socialization movement since early 1930's, but only recently has come out in favor of compulsory sickness insurance. Was double-crossed during drafting period of 1939 Wagner health bill and 1943 W-M-D bill, but collaborated with Falk in preparation of 1945 W-M-D bills. When, in accord with Reorganization Plan No. 2, which became effective July 16, 1946, the Federal Security Administrator appointed Social Security Commissioner Altmeyer to one of the two top posts in FSA as Assistant to the Administrator, he did not similarly elevate Dr. Parran. Thus, there is no representation of medicine in the top echelon of administrative authority in the FSA.

Cohen, Wilbur, J., A. B.: Came with Altmeyer from Wisconsin to serve as technical assistant on Committee for Economic Security, 1934. Moved along with Altmeyer to Social Security Board in same capacity. Assistant Director, Bureau of Research and Statistics, Social Security Board, under Falk. Attends meetings, does some ghost-writing, prepares papers for labor publications; puts sugar coatings on the bitter pills of compulsion.

Boas, Ernest P., M. D.: Born Worcester, Mass., 1891. Son of Franz and Marie (Krackowizer) Boas. B. S., Columbia, 1910; M. D. 1914. Medical director Montefiori Hospital, 1921–29; Columbia faculty since 1926; associate physician, Mount Sinai Hospital. Chairman Physicians Forum, Inc. Member of the four leading groups lobbying for nationalization of medicine. Member of National Citizens Political Action Committee and of at least eight Communist-front organizations. Active lobbyist and propagandist for nationalization.

Perrott, George St. John, A. M.: Chemist. Chief, Public Health Methods, USPHS. Joined PHS staff, Office of Statistical Investigations, 1933. Directed National Health Inventory, 1935–36, for which initial appropriation was $3,450,000. Worked closely at PHS and Milbank Memorial Fund with Edgar Sydenstricker, to whom he was related by marriage. (Sydenstricker was first statistician of PHS and Director of Research, Milbank Memorial Fund, 1928 to death, March 19, 1936.) Now has staff of 103 physicians, statisticians, economists, information specialists, and clerks. On June 17, 1943, was designated officially by Dr. Parran as PHS representative to "cooperate with" the technicians of the

Social Security Board "in the further development of the program" set forth in the 1943 W-M-D bill. Collaborates closely with Falk, making his staff available to him. A public relations man who sits on numerous committees organized for purpose of nationalizing medicine; travels extensively at taxpayers' expense; attended ILO meetings in Montreal, Mexico City, and South America. Spent 3 months in summer of 1946 with Dr. Mountin studying sickness insurance in Europe. In a genial way sells Falk's ideas to the uninformed, the unwary, and would-be social reformers.

Eliot, Martha M., M. D.: Associate Chief, Children's Bureau, Social Security Administration. President-elect APHA. More interested in her children's program than in compulsory sickness insurance. Has been associated on committees for many years with Falk.

Klem, Margaret C., A. B.: Chief, Medical Economics Section, Falk's staff, Social Security Board. Associated with Falk since CCMC days. Travels extensively to gather information; eyes and ears for Falk. When an attempt was being made to force compulsory sickness insurance legislation through the California Legislature in 1944, arrangements were made to have a CIO representative request Miss Klem's presence in California. She went there by plane at the taxpayers' expense to spend a month working with pressure groups.

Merriam, Ida C., Ph. D.: Labor economist. Chief, Division of Coordination Studies, Social Security Board, on Falk's staff. Has charge of contacts with AFL and CIO; engineers labor conferences, provides material for speeches and reports used by labor groups. Works closely with Katherine Pollak Ellickson, Assistant Director Reserve, CIO. Attended ILO meeting in Seattle, June 1946. Has organized a labor research group comprising directors of research of trade unions.

Sanders, Barkev S., Ph. D. Statistician. Chief, Health and Disability Studies, Social Security Board, on Falk's staff. Originally hired in 1937 to head a small statistical pool, he proved so useful in producing statistics as directed that when Falk was made Director of Research and Statistics in 1940, he gave his old job to Sanders. Regarded by other staff members at that time as professionally incompetent; still so regarded in many quarters. Extremely useful to Falk.

Switzer, Mary E., A. B.: Administrative Assistant to Watson B. Miller, Federal Security Administrator. Thoroughly conversant with administrative conditions under Falk regime. Collaborates with Falk; friendly to Perrott. Although not professionally trained in research, she has been appointed to technical and research committees, such as, the former committee on Long-Range Work and Relief Policies of the defunct National Resources Planning Board and the present "working committee" of the President's Research Board which held its first meeting January 2, 1947.

Mott, Frederick D., M. D.: Formerly a member of USPHS Reserve on loan to Farm Security Administration. Favored compulsory sickness insurance, collaborated with Falk. Farm Security Administration liquidated in 1946; prior to that Mott accepted position as Chairman, Health Services Planning Commission, Department Public Health, Saskatchewan, Canada.

Roemer, Milton I., M. D.: Formerly USPHS Reserve assigned to Dr. Mott's staff. Now a PHS commissioned officer on Dr. Mountin's staff. Active lobbyist for W-M-D bill: A council member of the Physicians Forum, Inc., admitted to be a lobbying organization to promote passage of the W-M-D bill. Has appeared on public platforms as advocate of Federal compulsory sickness insurance legislation. (E. g., see The Evening Star, Washington, D. C., June 7, 1946.)

Gross, Bertram, A. M.: Referred to in Newsweek as a "planner" and "Murray megaphone." Entered Federal Government 1938 at $2,600 in Federal Housing Authority; rose to $8,750 in December 1945, in RFC. Loaned to various Senate committees headed by Senators Wagner and Murray. Early in 1946 set up office in room 15A, Senate Office Building to engineer hearings on S. 1606. Watson B. Miller arranged to borrow Gross from RFC in spring of 1946 to serve as liaison between Federal Agency and Senate.

Malmberg, Carl, A. B.: Formerly clerk and ghost-writer on Dr. Mountin's staff, PHS. Was recommended to Senator Pepper and became clerk to Subcommittee on Wartime Health and Education, PHS paying his salary of $7,150. He attempted without success to expedite PHS and Children's Bureau bills through the Committee on Education and Labor. Left the Government during second session of Seventy-ninth Congress to join staff of Democratic National Committee.

Corson, John J.: Protege of Altmeyer; formerly Director, Bureau of Old-Age Insurance, Social Security Board. Now circulation director, recently research director, The Washington Post. Served on technical staff, House Ways and Means Committee which investigated social-security programs and administration in 1945. Deplores failure of Congress to enact health insurance legislation and predicts by 1975 "a system of social security which guarantees every family continual economic security." See his "Basic Issues of Security" (Public Welfare, October 1946, pp. 222–226–ff.).

Reed, Louis S., Ph. D.: Economist. On Perrott's staff, PHS. Formerly associated with Falk on CCMC and as Assistant Chief of Health Studies, SSB. Aided Perrott and Mountin in work on APHA platform, serving as secretary at APHA Subcommittee on Medical Care meetings in spring and summer of 1944. Engaged in study of Blue Cross plans; likely to give voluntary methods a pat on the back and a kick elsewhere. Collaborates with Falk.

Ring, Martha D.: Associated with Falk since CCMC days. Editor, Committee on Economic Security. Joined editorial staff SSB, becoming Assistant Chief, Publications and Review Division, June 21, 1939. Thoroughly indoctrinated with Falk viewpoint after 20 years' exposure thereto. Transferred to Perrott's staff, PHS, fall of 1946, to write his report on his 3 months' study of sickness insurance in Europe.

Stein, Peggy: Junior professional, formerly on staff of Dr. Mott at Farm Security Administration, later on Truman committee staff. Closely associated with M. M. Davis. Washington representative of Committee for Nation's Health, Inc., and member of Steering Committee of Washington, D. C. Chapter of Physicians Forum, Inc.

APPENDIX B

Fields of operation of the leaders in the movement to nationalize medicine

Year	Field of operation	I. S. Falk	M.M. Davis	G. St. J. Perrott	A. J. Altmeyer	W. J. Cohen	N. Sinai	J. W. Mountin, M. D.	Ernst P. Boas, M. D.
1927–1932	Committee on the Costs of Medical Care:								
	Executive committee		X						
	Research staff	X					X		
	Representing economics and sociology		X						
1928–1936	Rosenwald Fund: Director of medical services		X						
1934–1935	Committee on Economic Security:								
	Technical board				X				
	Hospital advisory board		X						
	Executive staff					X			
	Health insurance staff	X	X	X			X		
1933–1936	Milbank Memorial Fund: Research associate	X							
1936	American Association for Labor Legislation: Executive committee	X							
1935–1939	Interdepartmental Committee to Coordinate Health and Welfare Activities				X				
	Technical Committee on Medical Care	X		X				X	
1937–date	Committee on Research in Medical Economics, Inc		X						X
1937–date	Committee of Physicians for the Improvement of Medical Care, Inc								X
1939–date	Physicians Forum, Inc								X
1943–1944	Health Program Conference	X	X	X					X
1944	American Public Health Association: Subcommittee on Medical Care	X		X			X	X	
1944–date	International Labor Office:								
	United States delegate and member of Permanent Inter-American Committee on Social Security				X				
	Alternate to United States delegate			X					
	United States expert	X							
	Technical consultant					X			
1946	Committee for the Nation's Health, Inc		X						X
1946	Federal Hospital Council		X						

APPENDIX C

FEDERAL LAW CONCERNING LOBBYING BY FEDERAL EMPLOYEES

TITLE 18, SECTION 201, UNITED STATES CODE

201. *Use of appropriations to pay for personal service to influence Member of Congress to favor or oppose legislation.*—No part of the money appropriated by any act shall, in the absence of express authorization by Congress, be used directly or indirectly to pay for any personal service, advertisement, telegram, telephone, letter, printed or written matter, or other devise, intended or designed to influence in any manner a Member of Congress, to favor or oppose, by vote or otherwise, any legislation or appropriation by Congress, whether before or after the introduction of any bill or resolution proposing such legislation or appropriation; but this shall not prevent officers and employees of the United States from communicating to Members of Congress on the request of any Member or to Congress, through the proper official channels, requests for legislation or appropriations which they deem necessary for the efficient conduct of the public business.

Any officer or employee of the United States who, after notice and hearing by the superior officer vested with the power of removing him, is found to have violated or attempted to violate this section, shall be removed by such superior officer from office or employment. Any officer or employee of the United States who violates or attempts to violate this section shall also be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than $500 or by imprisonment for not more than 1 year, or both. (July 11, 1919, ch. 6, par. 6, 41 Stat. 68.)

(The second printing with three exceptions, appears to be identical with the third printing. The second printing contains no flyleaf, thus affecting the number of pages. The cover, appearing at this point, and the chart with footnote, are different. They follow in turn:)

BLUEPRINT FOR THE NATIONALIZATION OF MEDICINE

PLANS TO ENCHAIN MEDICINE BY REGULATIVE INTERFERENCE

(By Marjorie Shearon, Ph. D., Research Analyst)

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LEGEND

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Admin. Assistant

C HEALTH SERVICE

D., Surgeon General
, M.D.
Perrott, M.A.
D.

.D.

O F AGRICULTURE

D., USPHS Reserve
D., USPHS Reserve
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rrott, PHS
(FALK'S staff) SSB
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M E D I C A L CARE

rrott, PHS, Chrmn.
M.D., CB
(FALK'S staff) SSB
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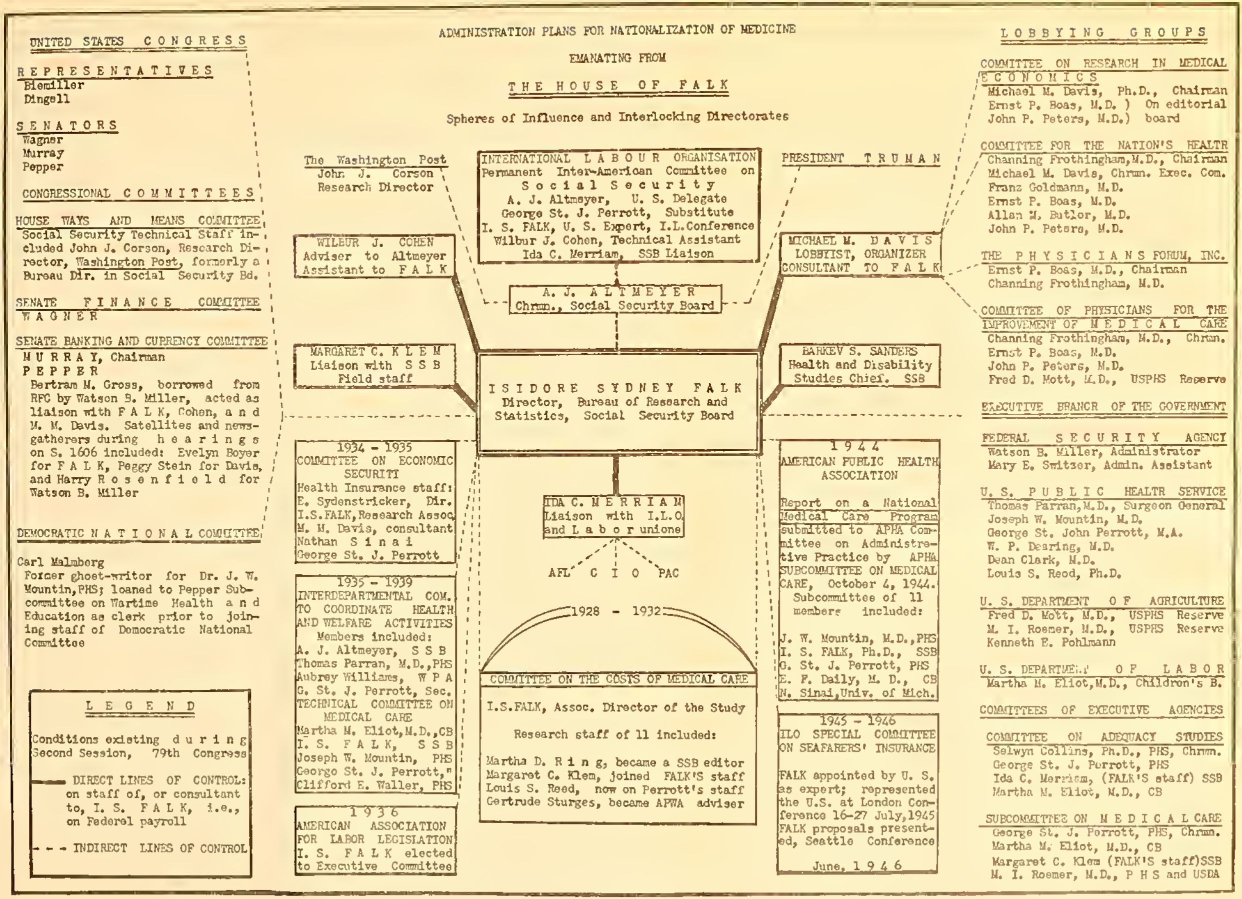
p. 1729) No. 2



ADMINISTRATION PLANS FOR NATIONALIZATION OF MEDICINE

EMANATING FROM

THE HOUSE OF FALK

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The Washington Post
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ISIDORE SYDNEY FALK
Director, Bureau of Research and Statistics, Social Security Board

BARKEV S. SANDERS
Health and Disability Studies Chief. SSB

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I.S.FALK, Research Assoc.
M. M. Davis, consultant
Nathan Sinai
George St. J. Perrott

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Louis S. Reed, now on Perrott's staff
Gertrude Sturges, became APWA adviser

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Report on a National Medical Care Program submitted to APHA Committee on Administrative Practice by APHA SUBCOMMITTEE ON MEDICAL CARE, October 4, 1944.
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G. St. J. Perrott, PHS
E. F. Daily, M. D., CB
N. Sinai, Univ. of Mich.

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EDITOR'S NOTE.—The author states that two errors appeared on this chart in the copy she handed to Senator Donnell for inclusion in the record. "Senate Finance Committee" should read "Senate Banking and Currency Committee" and "Senate Banking and Currency Committee" should read "Senate Education and Labor Committee." The third printing as copyrighted and distributed did not show these errors.

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BLUEPRINT FOR THE NATIONALIZATION OF MEDICINE

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(By Marjorie Shearon, Ph. D., Research Analyst)

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(The following notes prepared by Dr. Isidore S. Falk subsequently were ordered to be inserted at this point:)

NOTES PREPARED BY I. S. FALK ON BLUEPRINT FOR THE NATIONALIZATION OF MEDICINE, PUBLISHED BY MARJORIE SHEARON, IDENTIFIED AS "FIRST PRINTING JANUARY 1947."

(INTRODUCTORY NOTE.—I prepared the following notes in advance of these hearings on July 23, 1947, so that they would provide a basis from which to comment orally on Mrs. Marjorie Shearon's document entitled "Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Regulative Interference" which I expected Senator Donnell would bring up. These notes are, therefore, focused on specific items. Her document as a whole is, in my opinion, a false and malicious piece of propaganda and misrepresentation, based upon "falsification of facts and distortion of motives." In these notes I have attempted mainly to pick up such items as lend themselves to factual handling, to indicate those facts known to me which she has misstated or misrepresented, and to challenge other items in which—as far as I know—she has invented or misrepresented facts, or has utilized unreliable sources. This memorandum is included in the record of these hearings by permission of the subcommittee—I. S. FALK.)

Page 1706, paragraph 4

Does this make the United States of America a country "having a state socialist form of government" since 1935—when we adopted compulsory old-age and unemployment insurance, or since 1913 when we adopted a progressive income tax? Has each of our States (except Mississippi) and the Federal Government been practicing "state socialism" since the years when we adopted workmen's compensation—which is compulsory insurance against accidents? Note that Mrs. Shearon makes Bismarck a "state socializer."

Page 1706, line 36; p. 1707, lines 1 and 2

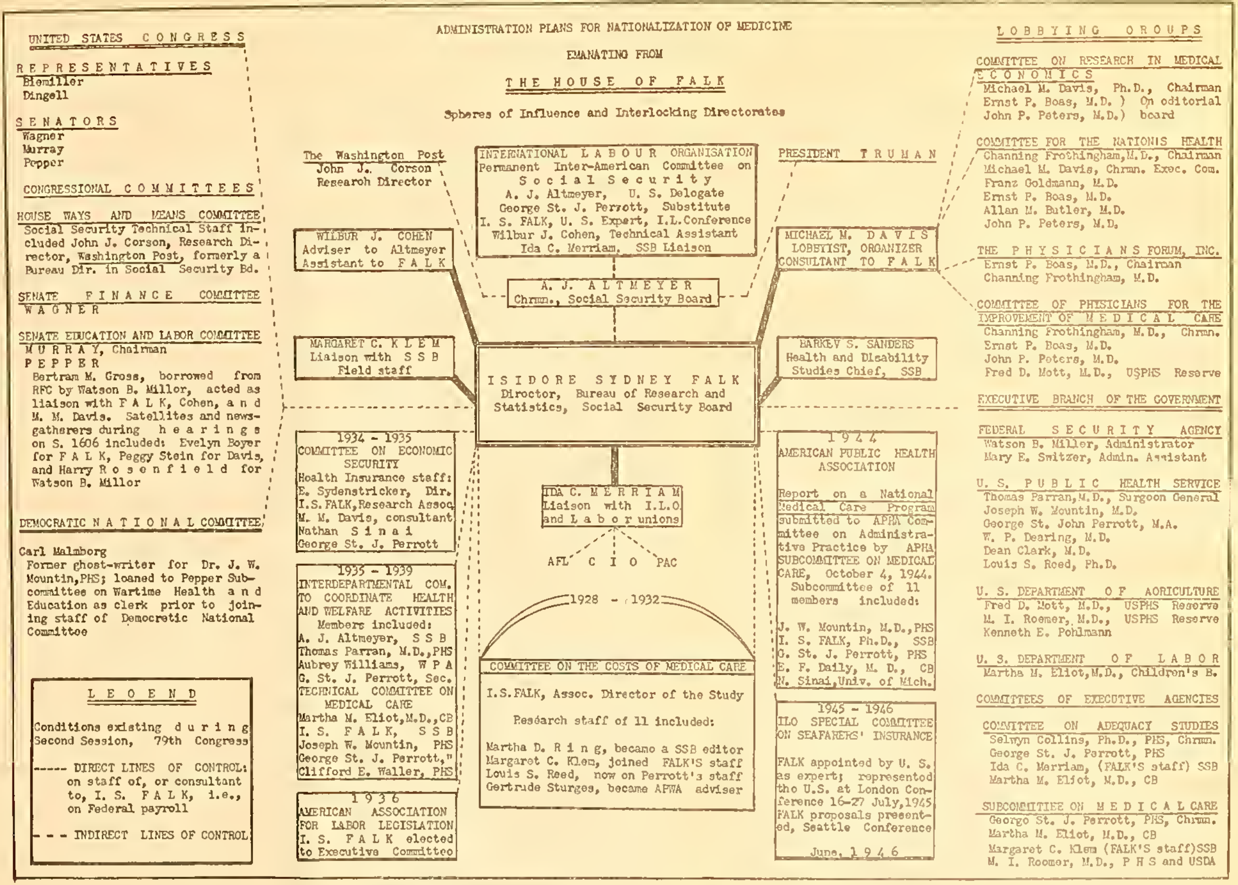
But note this is the new British system; not the health insurance they have had since 1911.

Page 1706, lines 3–5

The fee-for-service basis of payment is being used in compulsory insurance plans, and in voluntary plans (e. g., medical society plans).

Note that Boas—as well as others—accepted fee-for-service, as one of the alternative methods of paying doctors, in "Health Program Conference" report. Also note that Boas' objection here is in terms of "prohibitive cost" not administrative feasibility.

(The following chart appeared as described in the footnote, and is identified with the third printing:)



ADMINISTRATION PLANS FOR NATIONALIZATION OF MEDICINE

EMANATING FROM

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Spheres of Influence and Interlocking Directorates

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Margaret C. Klem, joined FALK'S staff
Louis S. Reed, now on Perrott's staff
Gertrude Sturges, became APWA adviser

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Subcommittee of 11 members included:

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I. S. FALK, Ph.D., SSB
G. St. J. Perrott, PHS
E. F. Daily, M. D., CB
N. Sinai, Univ. of Mich.

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FALK appointed by U. S. as expert; represented the U.S. at London Conference 16-27 July, 1945
FALK proposals presented, Seattle Conference

June, 1946

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M. I. Roemer, M.D., PHS and USDA

EDITOR'S NOTE.—The author states that an error appeared on this chart in the copy she handed to Senator Donnell for inclusion in the record. "Senate Finance Committee" should read "Senate Banking and Currency Committee."

Page 1707

The recommendations of the Social Security Administration have been clearly set forth in its annual reports to Congress. The policy issues involved have been seriously considered by millions of citizens and many groups throughout the country; they still await serious consideration by the Congress. There are sharp differences of opinion on those issues, as there have always been on important pieces of social legislation. The important fact is that the issues will be decided through the process of public debate and congressional action. In my opinion this attempt to link the Social Security Administartion and the ILO with Hitler is a piece of shabby demagogy.

Page 1707, footnote 4

Arthur J. Altmeyer is not and has never been "Assistant Federal Security Administrator." A relatively minor inaccuracy, perhaps, but revealing of the author's carelessness or disregard of facts.

Page 1707, last 3 lines; page 1708, first 6 lines

Note Shearon's editorial liberty. Davis (like a great many others) favored the (1), (2), (3) items cited—but Shearon precedes these with "Davis favored socialization of medicine by."

Page 1708, lines 9 and 10

Not "bacteriology" but public health; not "five," but six; and I was not connected with the "Chicago Medical School but with the University of Chicago." Mrs. Shearon seems to have difficulty in getting elementary facts of record straigth.

Page 1708, lines 11 and 12

This is a typical Shearon mixture of fact and misrepresentation. I resigned from the Chicago Department of Health "under fire" in this sense: The mayor had suddenly and without warning dismissed Dr. Bundesen, the commissioner of health and appointed Dr. Kegel. Directly after Dr. Kegel turned up in the office, he attacked me and other senior staff officers who had been close to his predecessor. According to the record, he didn't "request" my resignation, but made it impossible for me to stay on. If Mrs. Shearon read the references which she cited in her footnote 7, she knew all this. The Chicago Tribune item of December 23, 1927 says that my "ouster" "will be followed within a few days by the ousting of several other division and bureau chiefs * * * in a wholesale shuffle of jobs that will give Dr. Kegel an almost entirely new staff." The item of January 12, 1928 records that I resigned on my own motion. The item of December 15, 1929 has no connection with any of Mrs. Shearon's charges.

My files contain a letter from Dr. Jordan of February 16, 1927, in which he approved my taking the Health Department job on a civil service basis as proposed by Dr. Bundesen. He said:

"Up to the present the connection with the department of health has been for the most part of distinct benefit to the department and, I think, has laid a foundation for the development of our larger plans. I think you should discuss with Mr. Woodward the possibility of complications affecting the university in case of a radical change of administration or policy within the health department."

Also a letter of February 23, 1927, to Mr. F. C. Woodward, vice president of the university, confirming a conversation with him to go ahead with the proposal. Also saying:

"It is understood that I will carry the work in the department of health primarily for its value to our teaching and research in the University of Chicago and will present a resignation to the commissioner of health as soon as the duties of the director of surveys become sufficiently ardous or extensive to interfere with or to handicap my work in the University of Chicago.

"I may add again that no such difficulties are anticipated. Contrariwise, it is expected that the work in the department of health will supplement in a valuable way my work in the university and will provide the department of hygiene and bacteriology important and necessary opportunities for the development of its program in public health studies and teaching."

And a letter of February 25, 1927, from Mr. Woodward approving under the conditions stated in my letter to him.

Dr. Kegel didn't last long as commissioner of health and was succeeded by Dr. Bundesen who was reappointed in 1932 (by a new mayor, I think) and who is still in that office.

Resignation following a political turn-over constitutes resignation "under fire" to Mrs. Shearon.

Page 1708, lines 13 and 14

I never "put forth the claim that a cure might soon be forthcoming;" this is either a Shearon invention or is derived from some inaccurate source.

Page 1708, second (quoted) paragraph

Mrs. Shearon probably knows that this was a Fishbein "dig." He published a summary of our influenza report December 28, 1929 in the Journal of the American Medical Association.

Page 1708, third full paragraph, second sentence

Michael M. Davis was only one of many who helped organize the C. C. M. C.—including L. F. Barker, Winford H. Smith, C. E. A. Winslow, etc.

Page 1708, fourth full paragraph, last sentence

Shearon doesn't explain how a report with these stated recommendations has "been one of the mainstays of the state medicine propaganda effort."

Page 1708, fifth full paragraph, first 3 sentences

This is a Shearon invention. I didn't join C. C. M. C. until December 1929. In 1926–1934 there wasn't any "program for the socialization of medicine in the United States." See Shearon's own statement a few lines earlier as to the C. C. M. C. proposals. Also, note the names of the Foundations that supported C. C. M. C.

Page 1708, fifth full paragraph, last sentence

I would like to see the basis for these figures. The statement about them is Shearon rhetoric and invention.

Page 1708, last paragraph; page 1709, lines 1–4

So Bismarck was a socializer? This seems to say that Bismarck's "Blueprint" was to socialize the state—a new interpretation of Bismarck. But the next sentences seem to say (if they mean anything at all) that Bismarck used social insurance to break the "socializers." How, then, does she argue that others took over Bismarck's "Blueprint" to do the opposite?

Page 1709, first full paragraph

This is Shearon; most people would say they accepted social insurance on its merits, not on an ideological basis. Here, as in other capitalist countries, social insurance was developed and adopted as a support and a bulwark of our free-enterprise democracy.

Page 1709, second (quoted) paragraph

The United States of America agreed with this and adopted compulsory social insurance in 1935—by overwhelming bipartisan majorities in Congress. And, incidentally, what is wrong with this statement quoted from ILO? Read apart from the psychological effects of Shearon's style of writing to prejudice the readers, it strikes me that this statement would be accepted by nearly everybody in the United States of America.

Page 1709, fourth (quoted) paragraph

Notice what Mrs. Shearon does not emphasize in the last line of this quote—the purpose of compulsory insurance was to make workers "defenders of the capitalist system."

Page 1710, second full paragraph

Apparently to Mrs. Shearon anything favorable to a program is dismissed as "propaganda"; anybody for the program is a "propagandist"; and the more people who are for it, the more "propagandists." Incidentally, until very recently, Davis did not support compulsory insurance as against voluntary insurance.

Page 1710, third full paragraph, lines 1–3

"Seven years under the tutelage of Davis in the private propaganda field" is, to say the least, a Shearon-ese.

Page 1710, third full paragraph, lines 7–9

Normal, forthright research activities, publications, etc., are here given a behind-the-scenes flavor, a Shearon smear. There was nothing covert, concealed, or "behind the scenes" in the forthright recommendations of the Social Security Board, published in their annual reports and in statements to congressional committees or in public addresses.

Page 1710, third full paragraph, last sentence

Again, the technique of labeling social insurance with semantic names ("socialization," "nationalization") and then repeating them over and over again.

Page 1710, fourth full paragraph, first sentence

Mrs. Shearon is correct only to the extent that I worked on compulsory insurance (as well as voluntary insurance). The rest is misrepresentation, since the Milbank Memorial fund staff were working on public health programs, group-practice and health-center plans, community councils, professional education, etc.—e. g., many aspects of the C. C. M. C. recommendations.

Page 1710, last full paragraph

The depression did precipitate the Nation's interest in a program which, in 1935, became the Social Security Act overwhelmingly approved by Congress and never since then opposed by any substantial group of citizens and supported by both major political parties. Both Republican and Democratic platforms continue to endorse it and to support its strengthening and expansion.

Shearon seems to ascribe to me some major role in the enactment of the social-security program. I should be proud to be entitled to that credit; but anyone who knows the history of that enactment knows that I had only a very minor role in it—either in planning it, developing it, or in seeing it through Congress. Shearon's "build-up" is so much an exaggeration that it is false.

Page 1710, last 3 lines

Mrs. Shearon is correct that I was elected to the executive committee of the American Association for Labor Legislation. I knew nothing about it; those who elected me hadn't consulted me, and they apparently didn't know that I had accepted an appointment to the Federal Government. When I received the notice of the election, I declined it and was never a member of the executive committee.

Page 1711, lines 7–10

Not true. I was never active in the American Association for Labor Legislation, and I published in the Review (2?3?) papers over the years 1934 * * * (?) (I have not had time to check the precise facts).

Page 1711, lines 11–13

Shearon uses the present tense; she doesn't seem to know that the A. A. L. L. ceased to exist some years ago, de facto if not de jure.

Page 1711, first full paragraph

According to Mrs. Shearon, legislation authorizing U. S. A. membership in the ILO was "jammed through in a characteristic fashion"? And, later, Mrs. Shearon writes about how Secretary Perkins was "the prime mover in paving the way for entry of the United States into the ILO" (p. 712). And in her footnote 24 she invites the reader to see Miss Perkins' book (The Roosevelt I Knew, pp. 339–346) "for description of behind-the-scenes manipulation." The reader might expect that some chicanery went on. Knowing how little Mrs. Shearon can be trusted to give a true or objective account of facts or events, I read Miss Perkins' chapter "Approaches To World Order," pages 337–346. There I find she tells about broaching to President Roosevelt the idea of our joining the ILO, how the President advised her to go ahead, but said "Don't try to do this without the full assent and understanding of the Members of Congress primarily responsible for foreign policy." "Make sure that the men on the Senate Foreign Relations Committee have information and convictions about this idea of our going into the ILO." "Give them ample opportunity to examine all the facts," etc. "We'll go in if you can win the support of the Senate Foreign Relations Committee" (pp. 340–341). Miss Perkins then tells about her consultation with Secretary Hull, his approval to go ahead, their discussions for several weeks, how she furnished information to and had talks with members of the Senate Committee, and how several months later she had their agreement and support to go ahead (both Republican and Democratic), that Senator Harrison introduced a resolution and that it "went through without opposition" (p. 343).

Page 1711, last line, page 1712, lines 2–3

The ILO as "the center of an avowedly socialist set-up" is another liberty with fact and truth. "Accepted a commitment to further enactment of comprehensive social-insurance laws as a national goal" is nonsense. A member of the ILO makes only a commitment that it will give consideration to conventions and other agreements adopted by the ILO.

There is no indication here that Harold Butler (Great Britain's Minister to the United States during the war) was the second, and John Winant, former (Republican) Governor of New Hampshire, former (Republican) Chairman of the Social Security Board and our wartime Ambassador to Great Britain was the third director of ILO; and that in its organization and work it is tripartite (government, labor, employer) and that the American labor representatives have been selected from the A. F. of L. and the employer representatives have been a long series of thoroughly responsible representatives from American business. Are all these people also "socializers"?

The nonsense contained in this section on the ILO becomes further evident when considered in terms of the recent approval of the revised ILO constitution (to bring the ILO into its new relations with the UN). Recently considered by the Senate, a joint resolution of Congress was passed by unanimous action—with the active concurrence of Senator Taft. (See Congressional Record, June 2, 1947, pp. 6277–6278, 6302–6307.) (And all this is chronologically after Shearon's writing and after she had been working for some time with and in the office of Senator Taft as a member of the staff of the Republican National Committee and/or as "Research Analyst, Conference of the Minority, United States Senate." It would appear that even Senator Taft hasn't placed much credence in Mrs. Shearon's interpretation of the ILO or our membership in it.)

Page 1712, third full paragraph

This paragraph about our Bureau's Division of Coordination Studies is a tissue of Shearon misrepresentation. The Division of Coordination Studies was and is what its name indicates. It has had continuing contacts with all important labor groups (through a formal organized "labor research group") though Shearon mentions only CIO in this connection.

As for the PAC and the NCPAC, neither I nor the division has had any relations with them, direct or indirect. Shearon is building on the fact that we are acquainted with people who are in NCPAC, though, so far as I know, Davis (and Boas (?)) were members only of some local or medical subcommittee of NCPAC. Alexander I haven't met more than once or twice and that was many years ago, and Walsh I believe I have never met at all.

Page 1712, fourth full paragraph, lines 16–17

Mrs. Shearon is not correct about the "Health Insurance Staff." Drs. Davis and Sinai were added as adjunct members of the staff when Drs. Leland and Simons were added from the American Medical Association. Mr. Perrott, Miss Lenroot, and Dr. Eliot were never members of Sydenstricker's staff.

(I looked at Social Security in America to see what that showed. It lists all the names mentioned by Mrs. Shearon as on "Health Insurance Staff." Presumably this is where Mrs. Shearon got her material. But it is not correct. So far as I know, Dr. Draper, Dr. Thompson, Miss Lenroot, and Dr. Eliot were never on the Health Insurance Staff.)

(Note that Shearon mentions only those whom she is going to attack. If I am right in having guessed where she got the incorrect information, notice whom she does not mention—since that text also includes W. Frank Walker, deceased (Commonwealth Fund), Ira V. Hiscock (Yale University), R. G. Leland (AMA), A. M. Simons (AMA), and W. F. Draper (USPHS)—of whom the last three have been vigorously opposed to compulsory health insurance.)

Page 1713, first full paragraph, lines 9–11

Again a Shearon misrepresentation that I left the Milbank Memorial Fund "under fire." It had been agreed in the spring of 1936 that I would shift from the staff of the MMF to a grant-financed research project. Then Sydenstricker died suddenly some time later, and the whole program affecting me was dropped by mutual agreement—and solely on my motion—between me and the president of the fund. Instead, I accepted the invitation to join the Social Security Board staff, an invitation which I nowise sought.

(The Milbank Memorial Fund had been "under fire" in 1934 and 1935 in the sense of being under severe pressure to stop its health-insurance studies. The "fire" came from various medical societies and was directed to the fund and to the Borden Co.—Mr. Milbank was chairman of the board of this company. There was somthing in the nature of a medical "boycott" campaign against Borden products. Many of the facts of record on this episode are recorded in American Medicine Mobilizes, by James Rorty—W. W. Norton & Co., New York, 1939, pp. 116–130.)

Page 1713, first full paragraph, lines 12–17

There is some "slippery" writing here. Shearon knew very well that Reed, Klem, and Ring were in the employ of the Social Security Board before I was and that I had nothing to do with their employment. I was glad to have Reed and Klem on my staff when I had responsibility for organizing the Division of Health Studies, and later Ring when I became responsible for the Division of Publications and Review.

Page 1713, second full paragraph, lines 1–2

Davis was one of many consultants and he received almost no pay from Federal Government.

Page 1713, full paragraph, line 11

Perrott was not secretary of the Interdepartmental Committee in its early years. He was later, long after the Technical Committee was appointed.

Page 1713, full paragraph, lines 12–15

Technical Committee was appointed in 1937, rather than in October 1936.

(The Bulletin reference Shearon cites gives the date she quotes, but it does not apply to the Technical Committee. The proceedings reference gives no date for the Technical Committee.) What does she mean by "ultimately included"? These five were the committee.

Page 1713, last paragraph

Note the indirect and back-handed method of introducing something close to a Communist smear, which has not come in before this.

Page 1714, second paragraph, first sentence

Not true that the 1939 Wagner bill provisions "were drafted under Falk's direction." They were drafted by and under the direction of the whole Technical Committee, and under the direction of the Interdepartmental Committee, and with the participation of Senator Wagner and his staff. (Incidentally, also with Mrs. Shearon's participation.)

Page 1714, second paragraph, lines 5–7

Falk did not then or at any time since "claim that the only road to national health in this country was via federally controlled compulsory sickness insurance."

Page 1714, last paragraph, lines 4–8

Note that Shearon does not say, but implies, that Falk had something to do with the drafting of this bill and the inclusion of the quoted wording. The fact is that Falk had no contact whatever with that drafting or wording.

Page 1715, lines 3–7

I recall that Witte or someone else who was informed on the matter told us the AMA representatives objected to inclusion of the phrase "re health insurance" and that no objection to its deletion was raised because it would still be covered by the phrase "and related subjects."

Page 1715, first full paragraph

It is not true and has no basis in fact so far as I know for Mrs. Shearon to say that Congress considered and decided against giving the Social Security Board "a mandate to study health insurance." (See preceding note.) Note that nothing to support Mrs. Shearon's interpretation appears in the committee reports on the bill.

Page 1715, second full paragraph, lines 1–4

Shearon puts all this in the form of what Falk has "claimed." The basic fact is that the Social Security Board decided this matter when in 1936 they invited Falk to accept an appointment to their staff.

Also, until Shearon came along, with a new interpretation of section 702 of the Social Security Act, the Board's interpretation of section 702 was never questioned by the Budget Bureau and the congressional appropriation committees, the Congress, the Comptroller General, etc. The board's interpretation is still generally accepted.

Page 1715, second full paragraph, lines 9–10

The question might be asked whether it wasn't Shearon who furnished the "slanted" questions to the Appropriations Committee (or to those who handed them to Keefe, Engel, etc.).

Page 1715, third full paragraph, lines 4–6

"Well matured plans" is Shearon's invention, totally.

Page 1715, fifth full paragraph

All of this is obviously Shearon quackery, dragging the British developments in. Were we responsible for Beveridge, his appointment by the Churchill government, his report, its acclaim by all parties in Great Britain, the subsequent Labour Party victory at the British polls, and the implementation of the Beveridge report by a Labour Government instead of by a Conservative or Coalition Government?

Page 1716, second full paragraph, lines 1–2

Carter Goodrich has been off the ILO Governing Body or Board for some time.

Page 1716, second full paragraph

Note that Mrs. Shearon doesn't say (perhaps implies ?) that Falk had anything to do with the development of the maritime proposals, the preparation of the "model scheme of seafarers' social security," etc. The fact is that Falk didnt even know of these developments until he was asked by the Labor and State Departments to act for the United States Government in studying the proposals and, later, in going to the London meeting (already scheduled).

Page 1716, second full paragraph, last 3 lines

Mrs. Shearon's way of citing the principle that there should be one basic social-insurance system would never give the reader to understand that it leads to opposition against the special systems proposed for seamen in the ILO draft report.

Page 1716, third full paragraph, line 4

"Now or Never!" was whose slogan? This is a total Shearon invention.

Page 1716, third full paragraph, lines 6–8

A Shearon exaggeration. The facts are that in 1943 the Bureau had a budget of $189,000 (not "nearly half a million dollars"), and a travel fund of less than $3,000 (as against what she implies by "ample travel funds").

Page 1716, last full paragraph

Mrs. Shearon's eloquence completely ignores even such facts as she has already cited. She (p. 20) cited the Beveridge report (1942) which had already proposed "cradle to the grave" protection for everybody; but here she says "comprehensive coverage" and "comprehensive benefits" was a "revolutionary proposal" in 1943. The fact is, of course, that the discussions leading up to the Beveridge report in Great Britain and the report itself had made comprehensive social security a very active subject of discussion (in the press and in magazines) in Britain, the United States, and in many other countries.

In passing, what is wrong with extending social security to a whole population? Is Mrs. Shearon defending "workingman's insurance" or "poor man's insurance" or the older European models?

Page 1717, first full paragraph, last 4 lines

The bill contained a sound provision for consultation and clearance by the Surgeon General with the Social Security Board on financial commitments; and both were under the common direction of the Federal Security Administrator, with the latter authorized to settle disputes or override both.

Page 1717, footnote 43

1. Mrs. Shearon says we drafted two bills in 1943. This is not true; we drafted many drafts as we were working out many problems. If we talked about "our" draft that probably referred to what we ourselves worked out; and if we talked about an A. F. of L. draft we probably referred to a draft as prepared or amended by the A. F. of L. to whom (among others) Senator Wagner submitted his draft bill. I say this because I remember that we were asked to

comment on various changes, additions, and deletions proposed to Senator Wagner by the A. F. of L.

2. Her various statements about keeping Dr. Parran in the dark and not letting "him know what was being proposed" is Shearon imagination or ignorance of the facts. The fact is that the draft we were working out was sent by the Chairman (Mr. Altmeyer) to Dr. Parran March 17, 1943 (with a letter of that date) and discussed by them on March 20, 1943. Mr. Altmeyer told me (and Mr. Cohen) of Dr. Parran's comments and his suggestions for changes or clarifications. Mr. Altmeyer asked me to go ahead and work out the problems raised by Dr. Parran.

3. Mrs. Shearon says that "The Board submitted to Dr. Parran only 4 of the 17 major sections of S. 1161, or the equivalent of 34 of the 90 printed pages of the bill." This is a typical Shearon misrepresentation, because the reader would never guess that most of the bill dealt with subjects quite outside of Dr. Parran's field (e. g. a unified national social-insurance system; public employment offices; old-age, survivors and permanent-disability insurance; social-insurance protection for men in the armed services; unemployment, temporary disability and maternity insurance; unemployment-compensation allowances on termination of military service; social-insurance contributions and trust funds; a unified public-assistance program, etc.). Dr. Parran received all there was on the medical-care program (the whole of section 11 of the bill, and the supplementary sections on research, etc.).

4. Her final remarks about "seductively worded" parts that were not included in S. 1161 are, so far as I know, her rhetoric and that only.

Page 1717, third full paragraph

The Federal Advisory Council was strictly advisory and its functions were mainly on the broad social-insurance system; the Board of Trustees (Secretary of the Treasury, Secretary of Labor, and Fedeal Security Administrator) is a financial trustee (it is not clear why it should include medical representation); and there was no "vast administrative authority" of any kind vested in the Social Security Board for the health-insurance system. Its administrative authority was practically wholly concerned with using the common wage-record system to determine who is eligible to the benefits.

Page 1717, fourth full paragraph, lines 5–7

But the Surgeon General was consulted in 1943, as she admits in footnote 43 on the preceding page. As a matter of fact, she doesn't seem to know that Dr. Parran was consulted twice in 1943—the March consultations (already mentioned in reference above) and the May consultations. (The latter were nonproductive, because Senator Wagner introduced the bill unexpectedly to us, on June 3.)

Page 1717, fourth full paragraph, line 8

Who "induced" the Surgeon General to get on a "bandwagon"?

Page 1717, fourth full paragraph, lines 9–12

It is news to me that the "Administrator advised the Public Health Service to cooperate with the Social Security Board in drafting legislative proposals." Does the author imply that the Public Health Service should not work on legislative proposals relating to health insurance?

Page 1717, fourth paragraph, last 4 lines

The joint work on the dental and nursing studies was not "under Falk's supervision" even though Shearon italicizes these words. The fact is that Perrott and Falk were jointly responsible (by arrangement between Mr. Altmeyer and Dr. Parran), and shared the chairmanship of all meetings. The only special favor I enjoyed is that the technical exploratory conferences were held in my office (the Public Health Service people were located in Bethesda), and the subsequent conferences with the nursing and dental consultants were held in our building (Board room), with Perrott alternating with me in the chair.

Page 1718, line 13

Note the slanting re "clever move." Apparently there is, in Mrs. Shearon's philosophy, something wicked achieved if a bill she doesn't like gets referred to a committee that will give it a public hearing, rather than getting referred to another committee that will not.

Page 1718, first full paragraph

This tirade against the Health Program Conference Report is a complete perversion of the document and a gross misrepresentation of the group. Since it professed to be a conference of friends of a national-health program, why is it surprising that those whom Shearon says were leaders in this field should be members of it? And what's wrong about Government officers meeting with their professional colleagues to share in preparing a report—which expressly says each member of the group acted in his individual capacity?

Shearon's heading says that "Bureaucrats" drafted the report. The fact is that the Government members of the group participated in the conference but did not do the primary drafting.

Page 1718, second full paragraph, lines 1–4

It is my impression this is a misrepresentation; that Boas and Davis were members only of some PAC sub-subcommittee. And what does all this prove, and what is the honesty of this rhetorical point that "Senator Wagner likewise failed to state * * *"?

Page 1719, lines 1–3

It will be news to the Rockefeller Foundation that they had long been "active in the movement to socialize medicine"—whatever Shearon means by that last phrase.

Page 1719, lines 3–4

I don't know much about contributions to Davis' work, but as to "the work of Falk," neither Rockefeller nor Rosenwald Foundations had contributed a penny to anything I was connected with since the CCMC (1929–33). (Except for a small honorarium for a technical job I did for Rosenwald Fund in autumn of 1936 when between the Milbank and the Government jobs.)

Page 1719, first full paragraph, lines 6–8

Re "Falk's views about the separation of cash and medical sickness benefits," the reader wouldn't guess at this point these have also been Shearon's views.

Page 1719, second full paragraph, lines 13–14

Goldmann was never a "consultant" to the Social Security Board.

Page 1719, second full paragraph, last 3 lines

Is there something wrong in 29 people of like general view coming together to work out the major details of their general ideas? Does Shearon criticize the AMA for putting only members who oppose compulsory health insurance on one of its committees or councils?

Page 1719, third full paragraph, lines 4–6

What the "behind-the-scenes manipulation" was in the preparation of the APHA policy statement, only Mrs. Shearon knows. I don't.

Page 1719, third full paragraph, lines 7–10

Dr. Mountin advises that he definitely never said any such thing. On the contrary, he points out that the resolutions were developed and adopted in fullest accord with the provisions of the constitution and bylaws of the APHA.

Page 1719, third full paragraph, last sentence

The answer to Smillie's prejudiced and erroneous analyses (A. J. P. H., June 1945, p. 587) has been published in the J. A. M. A., but Shearon doesn't cite that (Journal, November 18, 1944, 126, 12, p. 789). See also Dr. Atwater's statements in hearings on S. 1320, June 27, 1947.

Page 1719, last paragraph

This is Fishbein editorial liberty (J. A. M. A., Oct. 14, 1944, p. 434), embellished by Mrs. Shearon. As is recorded in the J. A. M. A. for Nov. 18, 1944, the APHA principles were adopted through the prodecures prescribed by the APHA constitution and bylaws (not by Fishbein's or Shearon's prescription). Did Fishbein or Shearon ever criticize an AMA adoption because (according to the AMA constitution and bylaws) it was approved by the house of delegates and not by the fellows of the AMA or by the members? This very question is raised by Dr. Godfrey in the J. A. M. A. letter (Nov. 18, 1944).

Page 1721, last paragraph

It is shocking that Shearon "discloses" what happened in executive sessions of the Senate subcommittee, since she was there as Senator Taft's "expert." She fails to point out that I was there by invitation of the chairman (Senator Hill), as I presume she was; and that my contributions to the committee's work were by invitation of the subcommittee.

Page 1722, first full paragraph

Who wrote Manual 763? I'm not sure I've ever even seen it, and EM–29 I had never even seen or heard about until a few weeks ago, when I saw a printed copy for the first time.

Page 1722, first full paragraph lines 15–22

Here Shearon repeats her charge about "manipulated statistics;" but note that she has nowhere—so far as I know—ever undertaken to show objectively or specifically what statistics had been "manipulated" or where, by me or anyone in the group she criticizes.

Page 1722, third full paragraph

As far as I know, it is an invention that "the 1927 ILO recommendations * * * (etc.)" contain the "blueprint" that is contained in S. 1050. The 1944 ILO "principles" followed (not preceded) S. 1161 (June 3, 1943), the predecessor of S. 1050 (May 24, 1945); the American Government delegates did not approve or vote for the 1944 "principles"; and the United States Government did not then or thereafter approve or endorse them. Under the ILO constitution, the Government is obligated to transmit them to Congress; but note that in making such transmittal the President did not endorse or recommend them—he merely transmitted them.

Page 1722, last paragraph

This is all Shearon editorial writing, with her active imagination to help out. (Also, see above re p. 1711, last line.)

Page 1723, first paragraph

This is a gross misrepresentation and deception. Membership in the ILO and the Inter-American Conference commits the United States to no such policy. (See above re p. 1712, lines 1–3); see my notes on the article "Labor's Program to Socialize Medicine Internationally," Medical Economics, Nov. 1945, which appear later in these hearings.)

Page 1723, second full paragraph

Nationalization, socialization, etc., are Shearon's inventions—or those of groups like Dr. Fishbein's and the National Physicians Committee; and these paragraphs are a good sample of the kind of writing that is resorted to in the attempt to persuade people this is truth rather than what it is—a bogey-man invented by people with active imaginations and no respect for truth.

Page 1723, third full paragraph, lines 7–8

Note that earlier (p. 1715) Shearon challenged right of Social Security Board to study health insurance. Here (p. 1723) this has become "the clear intent of Congress that the Social Security Board should not study health insurance."

Page 1723–1724, quoted paragraph

It may be true that "all modern socialistic programs advocate schemes of social insurance * * *"; but it is also true that all (or nearly all) modern nonsocialistic programs also advocate social insurance. In short, since nearly everybody is in favor of social insurance, it is not surprising if socialists advocate it and try to take credit when it is adopted, or argue that it can be best administered under their system.

Shearon's basic misrepresentation here is by the trickery of substitution. A reader who didn't know the score would never guess from what she has said here that—not only the socialists allegedly advocate social insurance, but also—the Republicans as well as the Democrats advocate it. E. g., all or (certainly most) modern capitalistic programs advocate schemes of social insurance.

Page 1724, first full paragraph

Isn't the real point here that Europe has moved "left"—after the overthrow of the extreme "right" represented by Hitler and his kind—despite and not because of the limited socially protective achievements of "Bismarckian social insurance laws"?

Page 1724, second full paragraph

It is a Shearon "libel" (?) to identify those who believe in, advocate, and work for social insurance with those who are "engineering this world toward socialism." She applies all the epithets and cliches—boring from within, alien ideologies, international movement. By her line of reasoning, she—with a newly acquired Bourbon philosophy—"bored" her way first into the Republican National

Committee and then into the Senate Committee on Labor and Public Welfare (which more recently had to "fire" her). I say "newly acquired Bourbonism" since she abhorred and attacked means-test medicine when she was on our staff and vigorously advocated comprehensive compulsory health insurance.

Page 1724, last paragraph of page 1725

See earlier comments. If Shearon knows all these details, doesn't she also know that I had been earning as much as $10,000 a year before I came to the Government in December 1936? Or wouldn't it do for her to show that I got no financial advancement from Government employment—since she emphasizes that personal advancement is a reason or the reason for my activities?

Page 1725, first full paragraph, lines 6–13

This is news to me; never heard of any of these investigations before. From the fact that I never heard of them, could it be that the investigations (if conducted) did not find me guilty of these charges? On inquiry, I am also advised that our personnel officers have never known of these investigations.

Page 1725, third full paragraph

Again Mr. Altmeyer is not "Assistant Administrator." Note that he was again confirmed by the Senate for the job (in 1947) of representing the United States (to the Social Commission of the UN) after this Shearon pamphlet was published.

Pages 1725, fourth full paragraph, lines 5–10

This is a completely garbled account. Altmeyer is not and has never been either Assistant Administrator (as in the preceding paragraph) or Assistant to the Administrator (as here). Under the Administrator there are four operating branches, headed respectively by the Surgeon-General, the Commissioner of Education, the Commissioner for Social Security, and the Commissioner for Special Services. The latter two offices were created as a result of changes effected by Reorganization Order No. 2, and in no sense did the appointment of Mr. Altmeyer to the position of Commissioner for Social Security represent an elevation to a higher post. Since the organization of the PHS was not affected by Reorganization Order No. 2, there was no need to change the title of Dr. Parran's position.

Page 1726, third full paragraph, lines 3–7

As far as I know, it is Shearon invention that Miss Klem went to California on a request originating with the CIO. She went on the request of our regional director (Mr. Neustadt) to assist him in giving facts to persons interested in the bills and who were asking him for aid (this included Governor Warren). Indeed, Mr. Neustadt's subsequent request for an extension of Miss Klem's stay in California came from him by phone from the Governor's office, and Mr. Neustadt said the Governor requested that she be available for a longer period to work with his (the Governor's) assistants.

Not true or correct.

Page 1726, fifth full paragraph, lines 2–3
Re the chart

Shearon has dragged in everything she could compile of professional connections. Would it be difficult to draw a similar chart for anyone who occupies any position of consequence or responsibility in the Federal Government? Or to draw such a chart for Shearon herself?

Note the "dragging in" of people like Corson, Malmberg, etc. Corston's "staff" position with Ways and Means is absurd if I am correctly informed that he was only one of a number of consultants to that staff. Malmberg—whom I scarcely know—I presume is dragged in because he joined the staff of the Democratic National Committee.

Note that she has the Maritime Conference proposals all wrong. See Mrs. Merriam's article in the Social Security Bulletin, August 1946.

[In this connection, see also the print—attached—of her earlier edition of the chart. Note the heading.]

Many of her items are historical only, though as presented here are intended to give a "current" impression—witness the fact that the "legend" labels this as "conditions existing during Second Session, Seventy-ninth Congress." Obviously the chart collects various connections and associations Falk has had in the course of many years (1928 ff) of work in the field of health and shows them together. Obviously such a chart could be made up for anyone who has been active in professional or public affairs over a period of years.

Senator DONNELL. Mr. Falk, if you will turn to page 6, probably of your edition. It is under the heading "Evolution of plans and propaganda." That is the general subject matter. Do you see that?

Mr. FALK. Yes, sir.

Senator DONNELL. Do you see where it says—

> During the twenties Davis was joined by Isidore Sydney Falk, a man 20 years his junior, whose prior experience had been almost entirely academic and scientific.

On the same page further down you will see—

> He resigned from both positions under fire.

Mr. FALK. Yes, sir.

Senator DONNELL. And under footnote 7 it states:

> Dr. Kegel ousts health officials. Expect shake-up. U. of C. man dismissed by new department chief. Chicago Tribune, December 23, 1927; also Chicago Tribune, January 12, 1928 and December 15, 1929.

Senator MURRAY. Mr. Chairman, I have an edition of this pamphlet and I do not find this on page 6.

Senator DONNELL. What edition do you have?

Senator MURRAY. This is the second edition.

Senator DONNELL. Let me see. I will find it for you.

Senator MURRAY. Is it right at the top of the page?

Senator DONNELL. Right at the top of the page, yes.

Very well, Mr. Falk, you say you have no recollection of what actually transpired between you and Dr. Kegel over your dismissal or resignation, whichever the case was, from this office of director of the division of surveys. You have no recollection at all?

Mr. FALK. I have said that I do not recall as to details.

Senator DONNELL. I do not mean the mere details. Have you any recollection of what Dr. Kegel assigned to you as the reasons for wanting you to get out?

Mr. FALK. My only recollection is that in the first conversation I had with him, when he turned up in the office, he told me in effect that the sooner I left the happier he would be.

Senator DONNELL. I see.

Mr. FALK. As to what charges he may have made, I have no recollection.

Senator DONNELL. You were drawing $3,600 from the city at that time?

Mr. FALK. That is what it says in that article. I have no independent recollection of it.

Senator DONNELL. Do you not remember what salary you were drawing when you were only 28 years old?

Mr. FALK. I remember it was approximately that amount. Whether it was $3,600, I would not remember.

Senator DONNELL. You were drawing a salary at the University of Chicago. What was your salary at that time at the University of Chicago, let us say in 1927?

Mr. FALK. Again I would not be sure, but I think it was probably $4,000.

Senator DONNELL. The salary you were getting from the city was in the neighborhood of 40 to 45 percent of your total income?

Mr. Falk. Yes, sir.

Senator Donnell. Yet the circumstances involved in your dismissal did not make enough impression on your mind so you can tell us what reason Dr. Kegel assigned for wanting to get you out?

Mr. Falk. The general circumstances still remain with me. The details I do not remember.

Senator Donnell. Did he make the charge in substance to you at that time that you had taken some statistics and misinterpreted them in favor of your former chief?

Mr. Falk. I do not know anything about that. I have no recollection.

Senator Donnell. You would not affirm that or deny it?

Mr. Falk. No, sir.

Senator Donnell. Is this gentlemen still living, Dr. Kegel?

Mr. Falk. I do not know.

Senator Donnell. You do not know about that?

Mr. Falk. No, sir.

Senator Donnell. You gave a statement under date of January 12, 1928, to the press.

Mr. Falk. I do not remember.

Senator Donnell. Do you have a clipping from the Chicago Daily Tribune of that date?

Mr. Falk. Yes, sir.

Senator Donnell. Let me read it.

> U. of C. expert tells why he quit Dr. Kegel.

I pause right there to say in general your resignation was requested, you have just told us that the doctor said he was desirous of getting you out and the quicker the better.

Mr. Falk. Yes, sir.

Senator Donnell. The statement you gave to the Journal of the American Medical Association denying your resignation was requested is not correct?

Mr. Falk. That depends on how you interpret it. The new commissioner of health indicated he was not happy that I and others were there, that I and other persons there were uncongenial to him, and if we were not there he would be happier.

Senator Donnell. You knew he wanted you to get out?

Mr. Falk. I think so.

Senator Donnell. You knew it, did you not?

Mr. Falk. I cannot profess knowledge about what is alleged I knew in 1928. I can give my best recollection.

Senator Donnell. You knew he wanted you out and the quicker the better. That is substantially it.

Senator Murray. He did not state that he wanted him to get out.

Senator Donnell. What did he say?

Senator Murray. He said he would be happier.

Senator Donnell. It would influence——

Senator Murray. It does not indicate he was demanding a resignation or made the express statement he wanted him to get out.

Senator Donnell. You understood it would add to his happiness and peace of mind if you would leave. That is correct?

Mr. Falk. I think that is correct.

Senator Donnell. You know that is correct; do you not?

Mr. FALK. No, sir; I am only saying I think that is correct.

Senator DONNELL. To the best of your recollection is that correct?

Mr. FALK. Yes, sir.

Senator DONNELL. That is all right. Let me read the next sentence in the Chicago Tribune article:

> Dr. Falk states he resigned of his own volition, because of lack of sympathy for the new health commissioner's program.

That sentence indicates you were claiming you resigned of your own free will and accord because you did not sympathize with the program. That is not true?

Mr. FALK. He was trying——

Senator DONNELL (interposing). Now, I ask you——

Senator MURRAY (interposing). I want this witness to be afforded an opportunity to answer the question.

Senator DONNELL. That is all I want him to do; simply answer the question.

Senator MURRAY. I object to the chairman interrupting the witness and not giving him an opportunity to answer.

Senator DONNELL. Your objection is overruled.

Senator MURRAY. Let the witness answer——

Senator DONNELL. Your objection is overruled and the witness will answer and make such explanation as he wishes after he has answered the question.

Senator MURRAY. I want to have it noted in the record at this point that the chairman is arbitrarily refusing to permit the witness to complete his answer.

Senator DONNELL. He may complete his answer when this question is answered: Mr. Falk, it is true that you knew he wanted you out. That is correct?

Mr. FALK. Yes, that is correct.

Senator DONNELL. Now you may go ahead and make any explanation you wish in full.

Mr. FALK. Senator, as far as I can decipher what these articles deal with, they seem to focus on the question of whether I was dismissed or whether I resigned. Insofar as they go beyond that, for whatever additional light they shed, this statement in the Chicago Daily Tribune of Thursday, December 12, 1928, I interpret it—I wish to make a correction, it is Thursday, January 12, 1928. When I found it a few days ago I discovered that it was based upon a release from the Journal of the American Medical Association and not from me.

At any rate, I have had no independent recollection of this item in the newspaper, the statement of the Journal of the American Medical Association, or that any of these matters were of public record.

My first recent knowledge or recollection of these matters came when I looked up these references to the document by Dr. Shearon, allegedly supporting her statement "He had resigned from both positions under fire." At that time, knowing from long experience that her documentation of statements of that kind might not necessarily be accurate or trustworthy, I asked someone to find for me copies of these references and I obtained them. I regret to say we apparently did not follow up to secure the Journal of the American Medical Association or to look to see whether or not there was a statement in that journal. I have no knowledge on that, but I read this item in the Chicago

Tribune of January 12, 1928 when it became available to me and found it says I resigned of my own volition and my resignation was not turned in at Dr. Kegel's request, but of my own volition, at my discretion, and under the press of an immediate circumstance which was in a measure of my own creation.

I have no other knowledge or recollection at this time to what that refers.

The item goes on to say that:

> Dr. Kegel's plans and procedures and those of his advisers have made it impossible for me to remain in the Department of Health and retain my self-respect. My presentation of a resignation may have been desired but was not requested.

That means to me, if I am still responsive to your question, that Dr. Kegel had indicated to me he would be happier without me in the Department as well as happier without other people in the Department, but that he did not go so far as to request my resignation and that he did not dismiss me.

I may add parenthetically I was a civil servant. He may not have been free to dismiss me. I do not remember the details, but I do interpret this item to mean that he did not go so far as requesting my resignation, but that I precipitated circumstances, I presume, in my relations with him in which some forthright issue arose, and on the basis of which I submitted my resignation.

That is my interpretation of this item in the light of such recollection as I have of what transpired in December 1927 and January 1928.

Senator DONNELL. Now, Mr. Falk, have you completed your statement on that?

Mr. FALK. Yes, sir.

Senator DONNELL. I would like to read that article in full. I do not think you read the last sentence:

> "My resignation," Dr. Falk states, "was not turned in at Dr. Kegel's request, but of my own volition, at my discretion, and under the press of immediate circumstances which was in a measure of my own creation.
>
> "Dr. Kegel's plans and procedures and those of his advisers have made it impossible for me to remain in the Department of Health and retain my self-respect. My presentation of a resignation may have been desired, but was not requested."

Now, I return to your statement of a moment ago, and I want to ask you if on reflection you can think about "the press of immediate circumstances which was in a measure of my own creation" referred to. Can you recall now what that refers to?

Mr. FALK. No, Senator. I have no independent knowledge or recollection of it. I had no recollection, as I said earlier, of even this item in the paper. I obtained these only very recently and have not had opportunity yet to see what, if anything, I have in my personal files that may cast further light on it. I was planning to look into it because when I read this I was curious.

Senator DONNELL. You have the first edition of Dr. Shearon's book. What is the date of that edition? Look down at the bottom of the flyleaf.

Mr. FALK. There is a statement on the inside cover, first printing January 1947.

Senator MURRAY. I object to this being called a book. It is a propaganda circular, and one of these editions contains scurrilous material.

Senator DONNELL. Which edition is that?

Senator MURRAY. I do not know which one. One of the early editions.

Senator DONNELL. One of the early editions?

Senator MURRAY. One of the early editions.

Senator DONNELL. There have been three.

Senator MURRAY. They all contain scurrilous propaganda designed to confuse and befuddle the minds of people who would read the pamphlet.

Senator DONNELL. Mr. Falk, you have had this pamphlet for approximately 6 months in your possession, have you not?

Mr. FALK. I am not sure, Senator, how long I have had this in my possession.

Senator DONNELL. Well, have you had this several months?

Mr. FALK. Yes, sir.

Senator DONNELL. So you have had ample time to check on what the Chicago Tribune did say and what the Journal of the American Medical Association did say?

Mr. FALK. Had I been so alert as to inqure what those footnote references were I would have, but as I said, I did not look into these footnote references until just a little while ago, the last 10 days.

Senator DONNELL. But you read the booklet months ago.

Mr. FALK. Yes, that is correct, and I did make many notes of many inaccuracies and misconstructions, as in the case of one item, to which I refer as malicious and vicious misrepresentation with respect to the alleged circumstances under which I left the university.

Senator DONNELL. That is in one of Mrs. Shearon's pamphlets?

Mr. FALK. Yes, sir.

Senator DONNELL. Is that right?

Mr. FALK. Yes. I have reference to the sentence which you have just read that I resigned from both positions under fire. As the record indicates, I did not resign from the University of Chicago under fire, and that statement which has already been read was what I regard as a malicious misrepresentation. In another publication Mrs. Shearon is reported to have used stronger language, referring to me as having been dismissed from the university.

Senator DONNELL. The document before me states: "He had resigned from both positions under fire."

You are familiar with the Ramspeck committee over in the House?

Mr. FALK. Yes. I have heard of it. I would not say I am familiar with it.

Senator DONNELL. Are you familiar with a report of that committee that was prepared in 1944?

Mr. FALK. I am not. The only knowledge I have that there was a study and report by that committee is that which I derived from Mrs. Shearon's writing. I have made inquiry of those competent in the agency to know whether there ever was such a study and report, and they have told me they had no knowledge of it.

Senator DONNELL. You do know, however, there was such a report prepared?

Mr. FALK. I do not. I only know what Mrs. Shearon says about it.

Senator DONNELL. How did the denial get out of your office you presented a resignation to Dr. Kegel?

Mr. FALK. To the best of my present information based on these items we have been discussing——

Senator DONNELL. Do you not remember whether you resigned or did not not resign from office there in Chicago?

Mr. FALK. Senator, I repeat I have no independent recollection of the details of what transpired prior to having looked up these items cited by Mrs. Shearon. I really would not have felt competent to say whether I resigned or had been dismissed.

Senator DONNELL. You would not. Are the circumstances back there when you in some way terminated your position, a position involving $3,600 income, so unimportant that they did not leave any impression so you would remember whether you resigned or was dismissed?

Mr. FALK. The details have not remained with me.

Senator DONNELL. You do not actually remember now whether you were dismissed or resigned?

Mr. FALK. I have no independent recollection.

Senator DONNELL. As to whether you resigned or were dismissed?

Mr. FALK. At the city department of health?

Senator DONNELL. Yes, sir.

Mr. FALK. Yes; that is correct.

(For additional consideration on this point, see testimony of Mr. Falk of January 27, 1948.)

Senator DONNELL. You joined the Committee on the Costs of Medical Care?

Mr. FALK. That is right.

Senator DONNELL. Is it?

Mr. FALK. Yes, sir.

Senator DONNELL. Was there considerable publicity about a discovery it was stated you had made in regard to the isolation of the germ of influenza?

Mr. FALK. Yes, sir.

Senator DONNELL. There was a good deal in the papers. The New York Times of Friday, December 13, 1929, has a large article stating:

> Isolates germ of influenza. Dr. Falk, of University of Chicago, announces discovery of microbe of disease. Fourteen aides caught disease. Experiments conducted on monkeys have failed to bring successful vaccination. Antitoxin is sought. Bacteriologist, native of Brooklyn, names his find pleomorphaic streptococcus.

Do you remember that article?

Mr. FALK. No, sir; I do not.

Senator DONNELL. At any rate you gave out a statement with respect to the alleged discovery by you of a method of isolating the germ of influenza.

Mr. FALK. I do not think that is correct. I think what happened is a little different.

Senator DONNELL. What did you do?

Mr. FALK. My recollection of the fact is this, that I addressed an organization known as the Bacteriology Club of the University of Chicago, giving a summary of some findings, and unbeknownst to me the press was there.

Senator DONNELL. I want to correct a question. I think I have inadvertently misstated what this article says in this "Special to the New York Times." It is dated Chicago, December 12 and states:

> A year of research in the laboratories of the University of Chicago to discover and isolate the germ of influenza which has taken heavy toll of human life in 11 years has been crowned with success.

This is only part of it. You may see all of it if you like.

> This important announcement was made this afternoon by the discoverer, Dr. Isidore S. Falk, 30-year old professor of bacteriology at the university and a native of Brooklyn.
>
> The announcement was accompanied by a cautiously worded statement that there is "a hopeful prospect" that an antitoxin for influenza will be discovered.
>
> "What we are hoping," he said, "is that a vaccine prepared from dead microbes of the influenza germ can be absorbed through the mucous membrane of the nose and throat and thus effect a cure."

I am not so certain there was any error because it does say—

> The announcement was accompanied by a cautiously worded statement that there is a hopeful prospect that an antitoxin for influenza will be discovered.

That is what the article in the New York Times says. You are quite welcome to look at it. Let the record show Mr. Falk has been handed the article. We would be glad to have your statement on this, first on the announcement, and then the antitoxin to overcome influenza.

Mr. FALK. First may I point out for the record, the first paragraph which you have read aloud has to be read a little differently. As I read it "a hopeful prospect," I call attention to the fact the reference to antitoxin is not in the quote.

Senator DONNELL. I understand.

Mr. FALK. I make that point because, if I remember correctly, I think that is a statement Mrs. Shearon has ascribed to me, that I had once claimed a cure for influenza, a point not very important to accomplish national health legislation, but very important to a bacteriologist or immunologist, because an announcement of an antitoxin indicates one thing and what had been done with vaccines for prevention is quite a different matter.

Senator DONNELL. I do not know what you are referring to in Dr. Shearon's statement, but I think what she has said is this—it is page 8 of the third edition:

> Shortly before leaving Chicago in December 1929, he had received considerable publicity in the press as the "discoverer" of the germ of "flu" and had put forth the claim that a cure might soon be forthcoming.

Mr. FALK. That is what I have reference to, the first part of that sentence with reference to the discovery of the germ. That part is substantially correct, but what is not is the second part. The second part is based upon an inaccurate statement because I never worked on an antitoxin for influenza.

Senator DONNELL. What does the New York Times article say?

Mr. FALK. It says the announcement was accompanied by a cautiously worded statement that there is a hopeful prospect that an antitoxin for influenza will be discovered.

Senator DONNELL. Antitoxin is a cure?

Mr. FALK. That is not in the quotation. They do not directly ascribe that to me. I do not believe it came from me because I did no work on an antitoxin for influenza. That is very different from my work.

Senator DONNELL. Will you go ahead and read?

Mr. FALK (reading):

> "What we are hoping," he said, "is that a vaccine prepared from dead microbes of the influenza germ can be absorbed through the mucous membrane of the nose and throat and thus effect a cure."

Senator DONNELL. That is a quotation from you? Is that a correct quotation?

Mr. Falk. That I do not know.

Senator Donnell. Is it your best recollection that it is a correct quotation?

Mr. Falk. The general items it contains are as best I know correct. Whether that is a quotation from me I do not know.

Senator Donnell. But the factual items stated there in what purports to be a quotation from you are in your judgment substantially correct?

Mr. Falk. Yes, sir, except as to a reference to a cure instead of to prevention.

Senator Donnell. Go ahead.

Mr. Falk. Do you wish me to continue to read? I wanted to see what it contained and then I thought I would return to your original question about what my recollection is.

Senator Donnell. Go right ahead and look it over with care before you answer.

(The witness thereupon examined the clipping from the New York Times of Friday, December 13, 1929, handed him by Senator Donnell.)

Mr. Falk. Yes, Senator; I believe I did say my recollection was I made a report on our influenza experiment before the Bacteriology Club of the University of Chicago. It says Dr. Falk made his announcement today.

Senator Donnell. What date is that?

Mr. Falk. Friday, December 13, 1929.

Senator Donnell. That was only 18 days before you left the University of Chicago, was it not?

Mr. Falk. I think the letters I read earlier refer to my resignation as taking effect on December 31.

Senator Donnell. On December 31.

Mr. Falk. And those letters were written in September and October. I read that from the letter received from the secretary of the board of trustees dated October 17, 1929, and I read from letters beginning with August 5, 1929. I refer to those for the purpose of indicating what I think it is proper to indicate, that there is no relevance to this reference to 18 days because my request for a leave of absence or my submittance of a resignation if a leave could not be granted had been under negotiation from August on. My request was submitted to the vice president of the university on a date in September, acknowledged by him on another date in September and accepted formally by the board of trustees in October. All of this was long before the date of December 13th cited.

Senator Donnell. Where did you carry on your experiments on influenza? In the University of Chicago?

Mr. Falk. Yes, sir.

Senator Donnell. Did your associates working along with you know that?

Mr. Falk. Yes, sir.

Senator Donnell. Did the University authorities know that fact?

Mr. Falk. Oh, yes. They were financially supporting the work.

Senator Donnell. Did they know it at the time you wrote the first letter?

Mr. Falk. The responsible officers knew it.

Senator Donnell. Did Professor Jordan know, on August 5, 1929, you had been carrying on experiments with respect to flu?

Mr. FALK. Oh, yes.

Senator DONNELL. Who was he, what position did he hold?

Mr. FALK. Chairman of the Department of Hygiene and Bacteriology.

Senator DONNELL. Did he know of the fact your efforts were crowned with success? Did he know that?

Mr. FALK. I do not think that he knew or that anybody knew that in August.

Senator DONNELL. He knew you were working on that and it was an extremely important subject?

Mr. FALK. Yes, sir.

Senator DONNELL. He knew that in August?

Mr. FALK. Yes, sir.

Senator DONNELL. Still they accepted your resignation to take effect December 31, 1929?

Mr. FALK. Yes, sir.

Senator DONNELL. And while this was going on. Is that right?

Mr. FALK. Yes, and I might add from the clipping you handed me:

> Our researches at the University have been carried on since 1918 under the joint auspices of the University and the Influenza Commission founded and aided by the Metropolitan Life Insurance Co.

In other words, the influenza studies at the University of Chicago, in which I had a part, were a piece in a long stream of studies which had been going on since 1918, and much happened after I left the university.

Senator DONNELL. You had been working on this matter of influenza almost exclusively during the year 1929.

Mr. FALK. I do not think so.

Senator DONNELL. You had been working very diligently and putting in a large amount of time on it?

Mr. FALK. I think that is true.

Senator DONNELL. Had you been giving out publicity on the development during that period?

Mr. FALK. Not to my knowledge. I think there was no publicity until this story broke on it which is recorded here to be December 12th.

Senator DONNELL. 1929?

Mr. FALK. Yes.

Senator DONNELL. Dr. Jordan was your superior?

Mr. FALK. Yes.

Senator DONNELL. And he was away on an extended trip, was he not, in 1929?

Mr. FALK. I do not know whether he was away on an extended trip. That letter would indicate he was not at the university in the summer. Whether he was at his suburban home, I do not know.

Senator DONNELL. You do not recall how long he was gone?

Mr. FALK. No.

Senator DONNELL. You do not remember when he got back you and he had some discussion over your actions in connection with the influenza study? You do not recall that?

Let me ask you this question, do you recall that or not?

Mr. FALK. My recollection, Senator, would be that he was in Chicago at the time this story broke because I have some recollection of it, not very specific about this, but I do have some recollection of discussing with him the timing of the two publications of those studies, one which appeared in the Journal of the American Medical Association just about that time, and I do not remember the date, and the other was arrangement for full publication of the studies in the form of a monograph, and I do remember there was some discussion about the financing to pay for that publication because it is my recollection the special financing of that project was in the form of a grant from the Influenza Commission, furnished by the Metropolitan Life Insurance Co.

So, from this item it is my best recollection Professor Jordan was there.

Senator DONNELL. Professor Jordan did not express regret at your leaving?

Mr. FALK. I believe he did. I have some letters.

Senator DONNELL. From Professor Jordan?

Mr. FALK. Yes, sir.

Senator DONNELL. Do you have them here?

Mr. FALK. No, sir; I have not looked at my files of letters from Professor Jordan for some time.

Senator DONNELL. There was an article which appeared in the Journal of the American Medical Association on the 21st day of December 1929, which was just 8 days after the New York Times article, with respect to this article, which reads as follows:

> With little, if any, apparent warrant, it is again announced, for at least the tenth time in 5 years, that the causative organism of influenza has been discovered and that it is hoped to prepare a vaccine. There is thus far little or no evidence in scientific medical literature, or even in spoken addresses, to indicate that I. S. Falk, Ph. D., and his associates have progressed any further toward the solution of this problem than have workers in other parts of the world, now or in the past * * * the furore is inexcusable.

That is contained in the Journal of the American Medical Association, volume 93, No. 25, page 1975, December 21, 1929, and the quotation I have read is from Dr. Shearon's book.

Do you know whether that appeared in the Journal of the American Medical Association?

Mr. FALK. Yes, I do know it appeared. But that is not an article; that is a piece from the editorial column of Dr. Morris Fishbein.

There was a report in the Journal of the American Medical Association. Looking at my records, we published a report on December 28, 1929.

Sentor DONNELL. But the editorial comment made by Dr. Fishbein was as I read it?

Mr. FALK. I do not remember that I checked Mrs. Shearon's quotations, but I have no reason to doubt that it may be a correct quotation, except for my general hesitancy to rely upon anything she quotes as being necessarily accurate and reliable.

Senator DONNELL. Now, Mr. Falk, you left the University of Chicago to go with the Committee on the Cost of Medical Care. That is right, is it not?

Mr. FALK. Yes, sir.

Senator DONNELL. Mr. Davis was very instrumental in securing your appointment with that committee. That is correct, is it not?

Mr. FALK. I am not sure. It depends on what you mean by "very instrumental."

Senator DONNELL. Did he have anything to do with it?

Mr. FALK. Yes, sir.

Senator DONNELL. Did he recommend you?

Mr. FALK. No, sir; if you mean did he first recommend me.

Senator DONNELL. Did he tell you he did?

Mr. FALK. No, sir; and my best recollection is that the recommendation did not initiate with him. My best recollection is that I had never before met Mr. Davis, and, being in Chicago, he had been asked to talk to me about the possibility of my joining the committee's staff.

Senator DONNELL. It initiated with Dr. Moore?

Mr. FALK. No, it is my recollection that I was told it initiated with Prof. Haven Emerson of Columbia University.

Senator DONNELL. Did Mr. Emerson recommend you?

Mr. FALK. I do not know that he recommended it. I know he was a member of the executive committee and that he participated. I was told, I think, that he first brought up my name. All members of the executive committee who attended the meeting participated and concurred.

Senator DONNELL. At any rate, as you write in one of your letters here, if I may have it just a moment, in your letter of August 5, 1929, to Professor Jordan, you did state to Professor Jordan:

> You will recall that before you left I told you of my luncheon conference with Dr. Michael Davis and that he had asked me whether I might be interested in the work of the Committee on the Cost of Medical Care.

You so stated in your letter?

Mr. FALK. Yes, sir.

Senator DONNELL. Then you state:

> Some days later Dr. Moore invited me to attend the conference of the executive committee in Burlington. While there, he offered me an appointment as associate director of the staff of the committee.

You so stated in your letter of August 5, 1929 to Professor Jordan?

Mr. FALK. Yes, sir.

Senator DONNELL. Have you made any search for the letter from Professor Jordan to see whether or not he professed regret at your leaving the university?

Mr. FALK. No, sir.

Senator DONNELL. Would you mind making a search and see if you can find it?

Mr. FALK. Yes, I would be glad to. The way I recall it, very definitely Dr. Jordan was very reluctant for me to leave the university.

I have no knowledge, and I should not express this as a belief, but I hope I can find the expression from Dr. Jordan.

I do know that for many years until his death Professor Jordan and I were very good friends. We did not see each other very often, but whenever we did we were very happy to see each other, and I refer to that to indicate that I am sure my recollection is correct that Professor Jordan was reluctant to see me leave the university. I recall that he participated and succeeded in making the arrangements for the publication of my influenza studies after I left the university, and if there were any implication that Dr. Jordan acceded, if I may say, in the way Dr. Kegel acceded to my resignation from the Department of Health of the City of Chicago, I think that would be very unfair.

Senator DONNELL. You think Dr. Kegel acceded to your attempt to leave?

Mr. FALK. I think so.

Senator DONNELL. You are equally sure he offered no objections?

Mr. FALK. I think that is correct, Senator.

Senator DONNELL. All right.

(In response to Senator Donnell's request Mr. Falk subsequently submitted the following memorandum:)

A subsequent search of my files uncovers no correspondence within this period with Dr. Jordan. I do not know at this time whether there was any correspondence with him, or whether the discussions were oral only. My files do contain numerious letters exchanged with Dr. Jordan after I left the University of Chicago. They show that we had very friendly relations at the time I left the university and that they continued to be very friendly up to the time of his death.

Mr. FALK. I would like in the same connection to point out again that studies and arrangements for my resignation from the University of Chicago were initiated in the summer of 1929 and completed formally by October 17, 1929, and unless someone had a preconception of the future developing situation, it had no relation whatever with respect to these matters of the influenza study, and the publications to which your questions have been directed.

Senator DONNELL. In 1929 when you went with the Committee on the Costs of Medical Care, had you yet become connected with the Milbank Memorial Fund?

Mr. FALK. No, sir. I had no connection with the Milbank Memorial Fund until the work of the Committee on the Costs of Medical Care was completed and the committee offices were closed, except that the Milbank Memorial Fund was one of the financial supporters of the Committee on the Costs of Medical Care. It was one of a number of foundations which were giving financial support to the work of that committee.

Senator DONNELL. It was right after the Committee on the Costs of Medical Care was dissolved?

Mr. FALK. Terminated. It was a committee that had a 5-year program and expected to close its work at the end of the 5-year period, and it did. Very shortly after the 5-year program was completed, the committee went out of existence.

Senator DONNELL. In 1933 you became research assistant of the Milbank Memorial Fund; is that right?

Mr. FALK. Yes, sir.

Senator DONNELL. And you were in that capacity for about a year; is that correct?

Mr. FALK. No, sir; I think about 3 years.

Senator DONNELL. I should have said three years—from 1933 to 1936.

Mr. FALK. Yes, sir.

Senator DONNELL. In that connection you were closely associated with people from the Public Health Service of the United States Government who were working at that time for government medicine?

Mr. FALK. No, sir.

Senator DONNELL. You were not?

Mr. FALK. I do not know any people in the Public Health Service who were working for government medicine.

Senator DONNELL. Do you know a man named Dr. Sydenstricker?

Mr. FALK. I knew Mr. Edgar Sydenstricker very well. I forget his precise title. I think it was director of the staff, or something similar, for the Milbank Memorial Fund.

Senator DONNELL. He had been with the Public Health Service prior to that?

Mr. FALK. Yes, sir.

Senator DONNELL. He came from the Public Health Service to the Milbank Memorial Fund?

Mr. FALK. Yes, sir.

Senator DONNELL. Mr. Falk, is it not true that Mr. Sydenstricker was a statistician of the Public Health Service and later he was director of research of the Milbank Memorial Fund until his death on March 13, 1936? Is that correct?

Mr. FALK. I think so.

Senator DONNELL. You left the Milbank Fund in 1933?

Mr. FALK. No, sir; 1936.

Senator DONNELL. Would you tell us why you left the Milbank Fund?

Mr. FALK. Yes. I want to look at my notes to get my dates correct.

Senator DONNELL. That is all right.

Mr. FALK. My recollection, Senator, is that in 1933 when I went with the Milbank Memorial Fund, I went there on a temporary arrangement which was of an uncertain duration. It was an experimental undertaking, and then sometime a little later my appointment was made more definitive, and I think the appointment took the form of my becoming a regular member of the staff.

Then, in the spring of 1936 a new arrangement was made with the president and trustees of the fund that I would shift from a staff position in the Milbank Memorial Fund to work under a grant on a series of research projects.

It is my recollection the fund authorized an appropriation of money, if I remember correctly, for a 2-year program of study. We were in the process of exploration as to which university or other institution that grant would be made, when suddenly Mr. Sydenstricker, who had been director of the program and with whom this new plan had been developed, died.

He died very suddenly. On my motion, and solely on my motion, the plans for the grant program affecting my work for, if I remember correctly, the next 2 years, were dissolved and I left the Milbank Fund. I think it was at the end of that summer in 1936.

Senator DONNELL. The Milbank Memorial Fund gave you a year's salary and you went abroad and wrote your book on sickness insurance while you were there. Is that right?

Mr. FALK. No, sir.

Senator DONNELL. When did you write the book, Security Against Sickness: A Study of Health Insurance, by I. S. Falk, Doubleday, Doran & Co., Inc., Garden City, N. Y., 1936?

Mr. FALK. If I remember the facts correctly, my general recollection is that I began to work on this project in 1933. That must have been very soon after I first went to work with the Milbank Fund, and apparently more or less continued on this job through 1933, 1934, 1935, and 1936, except for an interruption in the summer of 1934 when I was asked with Mr. Sydenstricker to join the technical staff of President Roosevelt's Committee on Economic Security.

Senator DONNELL. What edition are you reading from?

Mr. FALK. There is only one edition of this book. I am reading from chapter 1, Introduction.

Senator DONNELL. Chapted 1, Introduction.

Mr. FALK. And I am reading from page 9. It goes on to say the work was interrupted because of my service on President Roosevelt's Committee on Economic Security. I would judge this book was finished sometime in 1936, when it went to press, and I believe it is dated as having been published in 1936.

Senator DONNELL. It was printed after the death of Mr. Sydenstricker because it was dedicated to Edgar Sydenstricker, 1881–1936.

Mr. FALK. My recollection is the volume was completed but the printing was not, because I still remember discussing the preparation of the item which appears on the flyleaf.

Senator DONNELL. You did go abroad shortly after terminating the arrangements with the Milbank Fund?

Mr. FALK. I went abroad before.

Senator DONNELL. Did you go afterward also?

Mr. FALK. That would be in reference to the trip abroad in the summer of 1936?

Senator DONNELL. You went with the Social Security Board in 1936?

Mr. FALK. Yes, sir.

Senator DONNELL. And you went in under the title of principal medical economist?

Mr. FALK. That is correct.

Senator DONNELL. As you have indicated, you are not a graduate of a medical school?

Mr. FALK. That is correct.

Senator DONNELL. Did you ever study economics?

Mr. FALK. I do not think I ever studied it formally. I have studied it.

Senator DONNELL. Have you not, as a matter of fact, stated you never had a day of economics in your life?

Mr. FALK. I do not think I ever said that.

Senator DONNELL. The title assigned to you was principal medical economist.

Senator MURRAY. At this point I would like to ask the witness if he will identify this appointment under which he took that office in the Social Security Administration?

Senator DONNELL. Yes.

Mr. FALK. Senator, I believe this is not the appointment under which I took that office. I believe the acting chairman is referring to the title assigned to the job to which I was appointed effective, if I remember correctly, December 1, 1936.

This document which you have handed me, Senator Murray, is, I believe, a Presidential appointment to the position of the same name, principal medical economist, August 4, 1937, and that is a subsequent appointment. Senator. In 1937 the original appointment to which Senator Donnell referred was superseded. The original appointment was a so-called expert appointment made by the Social Security Board after review and approval by the Civil Service Commission.

Senator DONNELL. The first appointment was principal medical economist.

Mr. FALK. Principal medical economist whereas the one Senator Murray has handed me was appointment by the President of the United States to the position of the same title, August 4, 1937, a subsequent Presidential appointment which required senatorial confirmation.

Senator DONNELL. That is an appointment by Franklin D. Roosevelt under date of August 4, 1937, nominating and appointing by and with advice and consent of the Senate Mr. Isidore S. Falk as principal medical economist in the Social Security Board.

That was the position to which you were appointed by the President for which you were to receive a salary of $6,400 a year?

Mr. FALK. I think the original appointment was at the base salary and carried $5,600.

Senator MURRAY. I would like to ask the witness to read this into the record.

Mr. FALK (reading):

> FRANKLIN D. ROOSEVELT
>
> PRESIDENT OF THE UNITED STATES OF AMERICA
>
> *To all who shall see these presents, greetings:*
>
> KNOW YE, that reposing special trust and confidence in the Integrity and Ability of Isidore S. Falk, of Connecticut, * * * I have nominated, and, by and with the advice and consent of the Senate, do appoint him Principal Medical Economist in the Social Security Board, and do authorize and empower him to execute and fulfill the duties of that Office according to law, and to have and to hold the said Office, with all the powers, privileges and emoluments thereunto of right appertaining, unto him the said Isidore S. Falk, subject to the conditions prescribed by law.
>
> IN TESTIMONY WHEREOF, I have caused these Letters to be made Patent, and the Seal of the United States to be hereunto affixed.
>
> Done at the City of Washington this fourth Day of August, in the year of our Lord one thousand nine hundred and thirty-seven, and of the Independence of the United States of America the one hundred and sixty-second.
>
> By The President:
>
> (Signed) FRANKLIN D. ROOSEVELT.
> (Signed) CORDELL HULL,
> *Secretary of State.*

Senator MURRAY. Mr. Falk, that appointment required confirmation by the Senate; did it not?

Mr. FALK. Yes, sir.

Senator MURRAY. Were you confirmed by the Senate?

Mr. FALK. Yes, sir.

Senator MURRAY. Was there any dissenting vote in that confirmation?

Mr. FALK. There were none, Senator, of which I had knowledge, and the Congressional Record indicates the motion to confirm was carried; that is, the confirmation of appointment was made without objection.

Senator DONNELL. Your salary was $5,600. That was the base salary?

Mr. FALK. I was appointed to the position to which you refer at the base salary of that grade, which was $5,600.

Senator DONNELL. I just want to get this record clear. I understand you were appointed in 1936 to the Social Security Board by the Board itself. Is that right?

Mr. FALK. Yes, sir.

Senator DONNELL. Not by the President?

Mr. FALK. Yes, sir.

Senator DONNELL. Your appointment by the Board in 1936 was as principal medical economist. What was the salary in that capacity?

Mr. FALK. I think when I first entered the duties of that job the salary was $5,600.

Senator DONNELL. That is, your appointment by the President on August 4, 1937, was at a salary of $6,400. Is that right?

Mr. FALK. Yes, that is correct, because in the interim my salary had been increased from $5,600 to $6,400 by the Social Security Board, while still holding the original position.

Senator DONNELL. You held this position to which you had been appointed in August 1937—you held it until 1938 when you were given the title of Assistant Director, Bureau of Research and Statistics; is that right?

Mr. FALK. That is not correct.

Senator DONNELL. What is the fact?

Mr. FALK. I think, sometime after the President's appointment became effective, those, like myself, with appointments of that kind were brought in under the civil service, and the position which I held by Presidential appointment was thus superseded by a civil-service position, October 7, 1938.

Senator DONNELL. What was the title of that civil-service position?

Mr. FALK. I think it had the same title, though I am not sure of that. A Division of Health Studies, if I remember the title correctly, was created and my position became that of Chief of the Division of Health Studies.

Senator DONNELL. When was that?

Mr. FALK. I am not sure that I know that date. I am sorry but I do not recall that date.

(Later the date of August 18, 1937, was supplied by the witness.)

Senator DONNELL. That was what you were appointed to by the President? What is the title?

Mr. FALK. Principal medical economist.

Senator DONNELL. That is not what he calls it there.

Mr. FALK. Yes, sir, it is.

Senator DONNELL. And you were also at that same time the Chief of the Division of Health Study, were you not?

Mr. FALK. I do not know whether it was at that time, before then or subsequent.

Senator DONNELL. You were made Chief of the Division of Health Study some time in the neighborhood of the time you were appointed by the President. Is that right?

Mr. FALK. I think it is approximately correct.

Senator DONNELL. Then you were promoted to the position of Assistant Director at $6,500 salary on November 7, 1938?

Mr. FALK. I will accept your statement, although I do not have the date.

Senator DONNELL. Shortly after your appointment, approximately a year and 3 or 4 months after you had been appointed by the President, you were made Assistant Director at $6,500?

Mr. FALK. What was the date?

Senator DONNELL. November 7, 1938, which I think is correct, that you were made Assistant Director.

Mr. Falk. My recollection is there is another interim step. I became Acting Assistant Director.

Senator Donnell. You did. In 1938 you were given the title of Acting Assistant Director?

Mr. Falk. That is correct.

Senator Donnell. Then you were promoted to the position of Assistant Director at $6,500 in November 1938?

Mr. Falk. Yes, sir.

Senator Donnell. Shortly afterward your salary was increased in December to $7,000 and thereafter, you were promoted to be Director of Research and Statistics in September 1940 at a salary of $8,000?

Mr. Falk. That is correct.

Senator Donnell. And you are now the holder of that position at a salary of $10,000 a year. Is that correct?

Mr. Falk. Yes. May I, before you leave that, say the record that has been introduced has not indicated however, that at the time I came into the Government service on December 1, 1936, I came from positions that had been paying $8,000 to $10,000 for a number of years.

Senator Donnell. In 1938 you were one of those who assisted in the preparation of plans for the National Health Conference called by President Roosevelt?

Mr. Falk. Yes, sir.

Senator Donnell. And certain recommendations were made by the National Health Conference about legislation. Is that right?

Mr. Falk. I am not sure that I can answer that categorically.

Senator Donnell. The conference was held, at any rate?

Mr. Falk. Yes, sir.

Senator Donnell. And you were very active in aiding and participating in it. That is correct, is it not?

Mr. Falk. Yes, sir.

Senator Donnell. Did you and your staff in 1939 prepare or assist in preparing the draft of the first Wagner bill, S. 1620?

Mr. Falk. I participated in the preparation of the draft as a member of the interdepartmental committee. My staff, I believe, participated in the preparation of one title of that bill. I am not sure whether their participation extended beyond one title of that bill or not.

Senator Donnell. Do you remember what title that was?

Mr. Falk. I will not trust my memory, Senator. I will ascertain it.

Senator Donnell. Just to refresh your memory, was it title XIII, grants to States for medical care?

Mr. Falk. That sounds correct, Senator. I can verify it.

Senator Donnell. Would you recognize it if you were to see it? I have a copy here. Page 34.

Mr. Falk. Looking at it now, I would say I am sure some members of my staff assisted in the preparation of the drafts which were eventually utilized by the interdepartmental committee for preparation of title XIII, and I would also guess, though I have no sure recollection of this, that members of our staff participated in preparation of underlying material which was used by the interdepartmental committee with respect to title XIV.

I do remember Mrs. Shearon and others were among those who did a large part of the underlying work in the case of title XIII.

Senator Pepper. Is that Mrs. Marjorie Shearon who is now sitting beside the chairman?

Mr. Falk. Yes, sir.

Senator Pepper. She was a member of your staff at that time?

Mr. Falk. Yes, sir.

Senator Pepper. And she participated with a number of your staff in the preparation of the underlying material for these sections?

Mr. Falk. Underlying drafts which were utilized by the interdepartmental committee.

Senator Donnell. And the particular title which Dr. Shearon and other members worked on was title XIII on page 34 of the bill?

Mr. Falk. Yes, sir.

Senator Donnell. And title XIII is entitled "Grants to States—Medical." Correct?

Mr. Falk. Yes.

Senator Donnell. The general underlying theory of that title was the United States Government could grant aid to States rather than having the United States Government go in and effect a national program?

Mr. Falk. The first part is correct, but the grant to State programs would still have been under national supervision.

Senator Donnell. I will change the question then. Title XIII did relate to grants to be given by the United States Government to States and the States were to operate the plan, using the money so derived from the grants together with other money. Is that correct?

Mr. Falk. That is partially correct.

Senator Donnell. What is the distinction?

Mr. Falk. They would utilize those Federal funds as grants in acordance with the requirements of the Federal statute, including the standards laid down as guides to the States and as a basis under which the Federal funds may be used and determining the use to which Federal funds are put.

Senator Donnell. You have read S. 545, now pending?

Mr. Falk. Yes, sir.

Senator Donnell. That is the bill which Senator Taft and Senator Smith and others are sponsoring?

Mr. Falk. Yes, sir.

Senator Donnell. That bill proceeds on the theory of grants to States?

Mr. Falk. Yes, sir.

Senator Donnell. And that is similar to the theory set forth in title XIII?

Mr. Falk. Yes, sir.

Senator Pepper. What was Dr. Shearon's attitude toward this matter of public health, Mr. Falk, at that time?

Mr. Falk. Senator, do you wish me to answer that in my own words or hers?

Senator Pepper. Well, in your own words, or hers, whichever way you may see proper.

Mr. Falk. I would prefer to answer it in her words rather than mine.

Senator Pepper. I would consider that would be good evidence.

Senator Donnell. Proceed, Mr. Falk. You remember her words?

Mr. Falk. Do I remember?

Senator DONNELL. Yes.

Mr. FALK. I would not profess to remember them. I could read them.

Senator DONNELL. You cannot remember what Dr. Kegel said to you there in Chicago?

Mr. FALK. No.

Senator DONNELL. But you think you would remember what she said if you read it?

Mr. FALK. I would remember with greater clarity events in 1938 than in 1928.

Senator DONNELL. Then what Dr. Kegel said to you referred to a position paying $3,600——

Mr. FALK. Whether I resigned or was dismissed, I was going to lose the $3,600 anyway. That would be the same. I do not quite understand.

Senator DONNELL. The point is, if you do not understand it, Mr. Falk, that $3,600 income, that question addressed by me would be a matter of considerable importance, and I imagine it would be of importance to almost anybody, and since you want to know what this point is, it would be rather reasonable for you to remember whether you were discharged or resigned in that connection.

Mr. FALK. Whether I resigned or was discharged did not determine whether my income would be $3,600 a year less. I, as an associate professor at the University of Chicago, was permitted to do other work. So, the $3,600 of that position, its loss coming from that position, is no measure of what happened to my income.

Senator DONNELL. Would you not assign such ultimate importance to the loss of a $3,600 position as would cause you to remember whether you were dismissed or resigned?

Mr. FALK. I do not understand that the loss of $3,600 was necessarily involved.

Senator DONNELL. You were losing a position of $3,600. I will not labor the point, but it would occur to me it would be reasonable to expect a man would remember with reasonable clarity whether he was put out or got out on his own volition.

Senator PEPPER. It is also probable that a man, who was the chief of a lady who at one time served under him in his field, who had distinct views, it may be the same lady has come to a position of great influence and takes the contrary position.

Whatever he has there as a quotation of Dr. Shearon's words——

Senator DONNELL. Yes; I will be glad to have it.

Mr. FALK. If I had not looked at the record I would only have had some general recollection about Mrs. Shearon's participation in the preparation of the underlying drafts.

As a matter of fact I had only a very vague recollection, since this matter is something that occurred 10 years ago, and I now have a clear recollection, but that I would ascribe to the fact I have looked at certain records.

Senator DONNELL. Go right ahead with whatever her statements are.

Mr. FALK. I have found in our files various documents prepared by Mrs. Shearon. They are associated with the development of documents which I have referred to as underlying drafts and which I would judge from the record—I have no independent recollection of this—were undertaken as a joint job by Mrs. Shearon and another member of our staff, Miss Margaret C. Klem. The files contain those various documents and they indicate Mrs. Shearon and Miss Klem were jointly working on the preparation of the draft to which I referred. Upon looking into the files we find there are some memoranda which are signed by Mrs. Shearon alone, and the files also indicate they were working in preparation of a joint document and also produced joint memoranda.

I have borrowed from our files a number of these documents. I have one before me which is dated September 12, 1938, with "M. Shearon" under it, and this is a document entitled "Notes on Specifications for a Draft Bill for Public Medical Care." I shall not undertake to read all of it, Senator, but I shall try to be responsive to the question which Senator Pepper addressed to me.

Senator DONNELL. Yes.

Mr. FALK. And I would like to be refreshed to be sure I understand the question.

Senator DONNELL. We want to know the views of Mrs. Shearon as bearing on S. 1620.

Senator PEPPER. That's right.

Senator MURRAY. These documents were all documents prepared by her or statements of hers in connection with these studies?

Mr. FALK. I should like to reserve on one point: whether they were all prepared only by her or whether some of them were joint preparations by her and Miss Klem.

Senator MURRAY. Now do you purport to read less than the whole document? If so, would you suggest that the whole document be put in the record? Or, would you care to read all of each document?

Senator DONNELL. If we have any of it, we ought to have it all.

Senator MURRAY. Read the entire document—each document separately.

Mr. FALK. Some of them are long documents, including draft bills.

Senator MURRAY. We have taken considerable time on this matter and we want to have the record complete on this phase as well as on any other phase.

Mr. FALK. I would only like to add then, if I may, I would not need to read all of them as responsive to Senator Pepper's question, but I shall be glad to read all of them if the committee wishes to hear them.

Senator PEPPER. You might read such parts as are pertinent, and then if somebody wants to read——

Senator DONNELL. I suggest we have it all in the record.

Senator PEPPER. It should all be in the record, and then you read such parts as are pertinent.

Senator DONNELL. We would like to have it all read.

Mr. FALK. You would like to have it all read?

Senator DONNELL. Yes.

Mr. FALK. May I get a supply of water?

Senator DONNELL. Yes. Read it all. We will take as much time as is necessary.

Mr. FALK. I am grateful, sir.

Senator DONNELL. If you will start in, let's hear it. This is September 12, 1938?

Mr. FALK. Yes; September 12, 1938, "M. Shearon."

Senator DONNELL. This is by her individually; is that right?

Mr. Falk. As far as I know.

Senator Donnell. It was in connection with the preparation of S. 1620; is that right?

Mr. Falk. Yes.

Senator Donnell. And that is the bill, the original Wagner bill—is that right?—introduced February 28, 1939. It was in connection with the preparation of that bill that this statement was made; is that correct?

Mr. Falk. Yes, sir. I think, if I understand what you are saying, Senator, that I have here documents which were staff documents not intended for any general use. They were intended only for intramural use at that time. They were part of the staff work that was being done in exploring and working out underlying specifications, clarifications of ideas, working out details as to how this or that might be done, spelling them out in one way and another way, as is usually done when staff people are exploring such matters.

Senator Donnell. In connection with the preparations of S. 1620?

Mr. Falk. In connection with what eventually became S. 1620.

Senator Donnell. All right. And that is the bill that was introduced of the original Wagner bills from which the Wagner-Murray-Dingell bill, with respective degrees of consanguinity, has emerged?

Mr. Falk. I don't know, sir.

Senator Donnell. All right; go ahead.

Mr. Falk. I make the point I have no knowledge or recollection at this time that at the time this draft was being considered it was anything more than a technical staff exploration, and therefore I would not really want to seem to be stating at this time that this was in any direct continuity known to us at that time or known to the staff members as relating to any particular bill or to that particular bill. This was, as far as I know, a staff exploration to work out possible ways and means of implementing certain general recommendations which had been made by the Technical Committee on Medical Care and the interdepartmental committee to which reference has been made.

Senator Donnell. Right at this point, this was to implement the recommendations made by the Technical Committee on Medical Care consisting of Martha M. Eliot, of the Children's Bureau; I. S. Falk, Social Security Board; Joseph W. Mountin, M. D., Public Health Service; George St. J. Perrott, Public Health Service; and Clifford E. Waller, Public Health Service?

Mr. Falk. And, Senator, of the Interdepartmental Committee to Coordinate Health and Welfare Activities, of which that was a subcommittee.

Senator Donnell. And the Interdepartmental Committee consisted of Arthur J. Altmeyer, Chairman, Social Security Board; Oscar L. Chapman, Assistant Secretary of the Interior; Charles V. McLaughlin, Assistant Secretary of Labor; and Milburn L. Wilson, Under Secretary of Agriculture. Is that right?

Mr. Falk. As of some particular date, because the membership was enlarged.

Senator Donnell. This was the date of the National Health Conference, held July 18, 19, 20, 1938, at the Mayflower Hotel, Washington, D. C.?

Mr. FALK. Yes, sir. The interdepartmental committee had some additional members added later; there may have been some other changes.

Senator MURRAY. These studies you are going to refer to here are studies that your department has been called upon to make at different times, or studies of a similar character that have been requested of you for other organizations and committees? You have done the same work for Senate committees, have you not?

Mr. FALK. Yes. Oh, yes; certainly. As well as, more importantly, by the direction of our own administrative superiors which at that time was the Social Security Board, or by the chairman of the Board.

Senator MURRAY. Did you do any work of this character for Senator Saltonstall in S. 1290, the school health bill?

Mr. FALK. You refer to a current bill, I take it, Senator?

Senator MURRAY. Yes.

Mr. FALK. Well, the Bureau has not done anything similar to this—namely, the preparation of underlying drafts or specifications.

Senator MURRAY. But have you assisted them in working out the phraseology of the bills they were undertaking to sponsor?

Mr. FALK. Well, in the case of the Saltonstall bill to which you refer, my recollection is that another bureau of our organization has been requested by that Senator, or by his secretary—I wouldn't be sure which—to help him work out some modifications or amendments of that bill and, in turn, since some aspects of that work involved work of my bureau, we too have been involved in the technical discussions.

Senator MURRAY. Are you familiar with the Senate bill 678 sponsored by Senator Lodge dealing with the subject of expensive medicines, X-rays, et cetera?

Mr. FALK. Yes, sir; I am.

Senator MURRAY. Have you rendered assistance in the study of that bill?

Mr. FALK. Yes, sir. But may I explain? The situation is, again, different from that which obtained in the case of the bill you have previously mentioned.

In the case of Senator Lodge's bill, I have no recollection that we had any consultations on that bill until after it had been introduced and had been referred to us for study. But it is my recollection that when it was being reviewed in our agency there were consultations in the course of the normal, the ordinary preparation of the agency's review and opinion of the bill; that there were consultations between Senator Lodge or his office and Dr. Parran, the Surgeon General of the Public Health Service, and staff members, following which various others of us, including myself, were involved in our agency's review of the bill and that as a result of our review of the bill there developed certain criticisms of the bill and those were made available to Senator Lodge; that he had further consultations with the Public Health Service, I believe. If I recollect correctly, a little while later, not long ago, Senator Lodge introduced an amendment in the nature of a substitute for the bill to which you have referred. At the time he introduced it, the Congressional Record shows that he referred to these consultations and said he had received certain suggested changes from, I think he said, the Public Health Service and had adopted them. I hesitate to say that he adopted all of them, but many of them, and embodied them in the amended bill which he introduced at that time.

Senator MURRAY. These studies, then, that you carried on in connection with S. 1620 were studies of the same character that you have carried on in connection with other bills?

Mr. FALK. Senator, I am not sure I know at this moment how to answer that question—whether I could answer it "yes" or "no," for this reason: I don't remember whether at the time when these documents that I have before me were being written—whether we were developing something in the nature of a bill that had been requested by any Senator or whether at that time we were merely exploring the development of the ideas formulated by the interdepartmental committee which may later have had a connection with Senator Wagner. I am not sure. It might have been either, and I don't profess at the moment to remember which.

Senator MURRAY. There is a bill pending here setting up a Bureau of Dental Research. Did you render any assistance in connection with the study of that bill and the preparation of that bill; do you remember?

Mr. FALK. Is that the bill you introduced?

Senator MURRAY. Yes. It is sponsored by myself, Senator Pepper, Senator Taft, Senator Aiken, and Senator Morse. It is on the calendar now. It is a dental research bill.

Mr. FALK. Yes. Well, if I recall the bill correctly, I would answer it this way. But let me first ask a question. Am I correct that that is a bill you introduced the year before?

Senator MURRAY. Yes. My recollection is that I did ask you to advise me with reference to the provisions of that bill.

Mr. FALK. Yes, sir. I do remember that now, and I tie it back to an earlier bill. At one time you asked me to come to see you and you gave me a draft of the bill which I believe had come to you from a dental group—I have forgotten, I do not profess to remember, whether they were a group of dentists acting in their individual capacities or whether they were acting for a dental association—and that you asked me to review that bill. I took it back and we reviewed and studied it. I remember that the review extended to consultations with the Public Health Service, which would have been very much concerned with the implementation of that bill. I remember having some conversations with Dr. Parran about some features of it, and with our general counsel. There may have been some staff review; there probably was. I believe I can recall that I not only furnished the results of our review to you but may have indicated what we thought were improvements, if we had criticisms. I have only a vague recollection, and I don't profess to remember all those details. I am not sure that I remember, Senator, that you asked me to review an amended draft later, though I think you did and that I did review it.

Senator MURRAY. Yes; I did.

Mr. FALK. And when the new bill was introduced my only recollection at the moment is that either I or members of my staff at my direction reviewed the new bill and found it either identical with or substantially similar to the older bill as it had been improved, so that I don't recall any more extensive review of that bill. But in that sense I do recall that we have given you assistance at your request in the review of that bill, as we have any committee chairman or Member of Congress who has requested such help.

Senator MURRAY. Have you been invited by other public organizations to appear before them to discuss problems of a like character?

Mr. FALK. I have had many invitations, Senator, to discuss problems with reference to legislation, but I always decline such invitations if they deal with pending legislation.

Senator MURRAY. Have you appeared before committees to assist committees of the Congress in giving them advice with reference to legislation?

Mr. FALK. Yes, sir. I have not had very much experience of that kind since most of the work of that kind in our bureau is done by another member of our staff. But I have had some occasions when I have been invited to assist committees of Congress and, of course, I have always acceded to their wishes.

Senator MURRAY. Have you appeared before the American Medical Association for the purpose of discussing matters pertaining to these medical problems?

Mr. FALK. Before the American Medical Association?

Senator MURRAY. Yes.

Mr. FALK. No, sir; I have not, personally.

Senator MURRAY. Have you had anything to do with the study of the hospital bill which we have had here a short time ago?

Mr. FALK. Are you referring to the hospital survey and construction bill?

Senator MURRAY. Yes.

Mr. FALK. Yes, sir; I did.

Senator MURRAY. That is all.

Senator DONNELL. Now, Mr. Falk, I wanted to ask you this. You said something about implementing the recommendations of the Technical Committee on Medical Care and of the Departmental Committee to Coordinate Health and Welfare Activities. I want to ask you if you presented at the National Health Conference July 18, 19, and 20, 1938, called by the Interdepartmental Committee to Coordinate Health and Welfare Activities at the Mayflower Hotel in this city, the report of the Technical Committee on Medical Care?

Mr. FALK. No, sir. I presented a part of it.

Senator DONNELL. I have in my hand a volume entitled "National Health Conference July 18, 19, and 20, 1938, Called by the Interdepartmental Committee to Coordinate Health and Welfare Activities, Mayflower Hotel, Washington, D. C."

On page 55 is this heading, which takes up the page: "Report of the Technical Committee on Medical Care to the National Health Conference, session V, Tuesday Evening, July 19, 8 p. m., Arthur J. Altmeyer, chairman. A. A general program of medical care. B. Insurance against loss of wages during sickness. Presented by I. S. Falk, Social Security Board" and "Discussion."

Did you prepare this report which thereafter follows and which consumes some 19 pages or thereabouts?

Mr. FALK. That is, Senator, my answer is——

Senator DONNELL. Well, did you present this phase?

Mr. FALK. I haven't seen the document but I think the answer is "Yes." But that is not what I understood you first to have asked me. May I explain why I seem to have been uncertain about it?

Senator DONNELL. Certainly.

Mr. FALK. The matter to which you refer, Senator, is session V of this conference, and the document, I believe without examining it closely, is one of a series of presentations, and this one which I presented as one of the members of the Technical Committee on Medical Care dealt with—let me read this statement:

> Attention may now be directed to the fourth major problem; the financial burdens and the economic insecurity which sickness creates for self-supporting persons.

having just been preceded by the statement that—

> The Technical Committee on Medical Care has called attention to the notable advances made in recent years in the prevention and cure of disease. The Committee has also called attention to the fact that there are serious inadequacies in the health services of the Nation. In the report transmitted by the Interdepartmental Committee to the President in February, the existing deficiencies were summarized in four broad categories. Of these, the conference has already considered three:

And then the three are listed:

> (1) Expansion of public health, and maternal and child-health services;
> (2) Expansion of hospital, clinic, and other institutional facilities; and
> (3) Provision for the medical services of needy and of medically needy persons.

Then comes the sentence to which I referred:

> Attention may now be directed to the fourth major problem: the financial burdens and the economic insecurity which sickness creates for self-supporting persons.

From there on, my presentation dealt with just that part of the Technical Committee's report.

Senator DONNELL. So the Technical Committee on Medical Care then, in the report which you presented at this session V, set forth its views, and I just quote the headings—not the document itself:

> A general program of medical care; Sickness burdens of self-supporting persons; Total costs and private expenditures; Income and health needs; Income and receipt of care; Uneven burden of medical costs; Medical need and ability to pay for adequate care; Incomes of practitioners and institutions; Inadequacy of voluntary insurance.
>
> The Committee's recommendation; Federal grants-in-aid to the States toward the costs of a more general medical-care program; Expansion of public medical services in the States; Development of health insurance by the States; State choice of program—

in the course of which I observe this:

> The choice of method or combination of methods should, in the opinion of the Technical Committee on Medical Care, be made by the States rather than by the Federal Government.
>
> An estimate of Federal costs, Insurance against loss of wages during sickness. Part I: The incidence of disability; Total and average incidence of disability; Uneven incidence of disability; An estimate of the permanently disabled.
>
> Part II: The Committee's recommendation. Recommendation V: Federal action toward the development of programs of disability compensation; Different insurance provision for temporary and permanent disability.

Then the "conclusion."

Now, those are the headings, Mr. Falk, of this report. And I understood you to refer to the fact that your office and your staff were working prior to the presentation of S. 1620 to Congress in an effort to implement both that report and the report of the Interdepartmental Committee to Coordinate Health and Welfare Activities. Did I understand you correctly?

Mr. FALK. No, sir. You did not.

Senator DONNELL. In what respect did I misunderstand you?

Mr. FALK. I believe the substance of what I said was that we were working on the task of trying to see how one would go about thinking through and spelling out—"we," I am referring to the Technical Committee on Medical Care. That is a subcommittee under the direction of the Interdepartmental Committee to Coordinate Health and Welfare Activities.

Probably, Senator, it will be more helpful if I go back and sketch in and lay a basis.

Senator DONNELL. All right.

Mr. FALK. The technical Committee on Medical Care made a study, developed its reports, submitted them to the Interdepartmental Committee. I will omit the modus operandi. It, at any rate, developed a report in which the results of its studies took the form of certain presentations of evidence, certain analyses of their findings and, finally, certain recommendations with respect to medical needs as the committee saw them.

Senator DONNELL. Was this the report presented by you on July 19, 1938?

Mr. FALK. No, sir. I am referring to the report of the whole Committee.

Senator DONNELL. All right.

Mr. FALK. That report ended with five recommendations dealing respectively—excuse me, Senator, I can do it more briefly from that report of the National Health Conference.

Senator DONNELL. All right.

Mr. FALK. That report ended with five recommendations: The first, expansion of public health, and maternal and child health services; another with respect to expansion of hospital, clinic, and other institutional facilities; the third was concerned with provision for the medical services of needy and of medically needy persons; a fourth was concerned with—and this is not the actual wording of the recommendation—the financial burdens and the economic insecurity which sickness creates for the people above the level of the needy; and the fifth dealt with the problem of income loss resulting from disablement. That was the report of the Technical Committee on Medical Care, a five-point series of recommendations.

The Interdepartmental Committee's report, which was a separate report, recast the recommendations of the Technical Committee and that report emerged with four recommendations. I am referring now to the parent committee, the Interdepartmental Committee, whose membership as of the summer of 1938 Senator Donnell referred to.

Senator DONNELL. Would it be at all helpful to you to have this, as I understand it, final copy of the proceedings of the National Health Conference before you?

Mr. FALK. Thank you kindly, Senator, but I have the actual report of the Committee.

The recommendations of the Interdepartmental Committee, as I have said, were four in number as against five in its subordinate committee's report. The four recommendations of the Interdepartmental Committee were, A. Expansion of the existing Federal-State cooperative program——

Senator DONNELL. What are you reading now, Mr. Falk, if you please?

Mr. Falk. This is the report of the Interdepartmental Committee as embodied in the House of Representatives Document No. 120 of the Seventy-sixth Congress, the first session, transmitted to the Congress by the President, Franklin D. Roosevelt.

Senator Donnell. What date?

Mr. Falk. On January 23, 1939. It is one of the very convenient printings we have available of these various documents. On that day the President transmitted the report and recommendations on national health by the Interdepartmental Committee to Coordinate Health and Welfare Activities, including also the report of the Technical Committee on Medical Care, a subcommittee of that Interdepartmental Committee, along with a message of his own, to the Congress of the United States.

Now, I said the Interdepartmental Committee recommendations were four in number—and this is important for a number of the other matters we have ahead of us, because some confusion has arisen in the literature of this field—as distinguished from the five recommendations of the Technical Committee. The first——

Senator Donnell. The four recommendations came out after the five recommendations in point of time; is that right?

Mr. Falk. I think that is probably correct, Senator. I think that is probably correct.

Senator Donnell. Off the record.

(There was a discussion off the record.)

Mr. Falk. I think I can summarize these four recommendations or read the actual text of them. It may be a little easier to understand it.

Senator Donnell. Use your own judgment, Mr. Falk.

Mr. Falk. I will read it. The first recommendation:

> The committee recommends the expansion and strengthening of existing Federal-State cooperative health programs under the Social Security Act through more nearly adequate grants-in-aid to the States and, through the States, to the localities.

Under that, they have: 1, dealing with general public-health services, and 2, dealing with maternal and child-health services.

Then, their second recommendation, labeled "B"——

Senator Donnell. Do you have an extra copy of that document?

Mr. Falk. I am sorry, I haven't.

In recommendation B:

> The Committee recommends grants-in-aid to the States for the construction, enlargement, and modernization of hospitals and related facilities where these are nonexistent or inadequate but are needed, including the construction of health and diagnostic centers in areas, especially rural or sparsely populated, inaccessible to hospitals. The Committee also recommends grants toward operating costs during the first years of such newly developed institutions to assist the States and localities in taking over responsibilities.

The third recommendation, C:

> The Committee recommends that the Federal Government provide grants-in-aid to the States to assist them in developing programs of medical care.

And the fourth recommendation, labeled "D":

> The Committee recommends the development of social insurance to insure partial replacement of wages during temporary or permanent disability.

Now, if one were to make a comparison of these four recommendations with the five recommendations of the Technical Committee, what would emerge is this, that the third and fourth recommendations of the Technical Committee were in substance merged into one recommendation of the Interdepartmental Committee, the recommendation C; that where the third recommendation of the Technical Committee dealt——

(At this point the bell sounded.)

Senator DONNELL. The committee will be in recess.

(After recess.)

Senator DONNELL. The committee will be in session.

Senator SMITH. The Senate is about to call the calendar, and since we are all very much concerned with that and the difficulties involved in the winding up of the session, after conference with the members here, the subcommittee has decided that we will adjourn these hearings now, subject to the call of the chairman, until the Congress reconvenes in January. So the meeting will be adjourned.

I regret the inconvenience, if it is an inconvenience, to the witness, but we realize that there is much more information that is very valuable which he can give us. We simply have not the time, either today or tomorrow with our other commitments, to go into this as we would like, and so it seems wise to the members of the committee to adjourn at this time subject to the call of the Chair early in January.

Senator MURRAY. Mr. Chairman, I am not objecting to it—I am consenting to it. In fact, I thought we should have adjourned several days ago, and should not have undertaken this today because I knew that we could not conclude it. But the witness is here now and I would like to ask him if this inconveniences him in any way.

Mr. FALK. Did I understand——

Senator MURRAY. Would you like to continue with your testimony? You have no objection to staying here for several days, if necessary, to conclude your testimony at this time if the committee so desires?

Mr. FALK. Not at all, Senator. I would be very glad to assist the committee through these hearings for any length of time the committee would like to have me. I can keep right on as long as my physical and mental capacity permit and as long as the committee wishes.

Senator SMITH. We feel we must adjourn because of this congestion, but we feel you could help us out by continuing your story in January and perhaps by developing it further in the meantime so that you can give us the whole picture of the build-up of the legislation in this field.

Mr. FALK. Senator, I shall, of course, accept, as I should, most properly, whatever the committee's decision is. I am a little reluctant to have to go through the process again another time, as you can appreciate, of refamiliarizing myself with memoranda and documents and historical data and chronologies, from my selfish, personal point of view and that of my office. It would be much more convenient to me to dispose of this matter and give the committee all I have, but I should be glad to accede to whatever the committee's wishes and decisions are and will be glad to be available on another occasion.

Senator DONNELL. Mr. Falk, you will have the record so you can pick up where you left off.

Senator SMITH. Even though a few months intervene, you can pick up where you left off when you come back. And we will ask the other witnesses who were expected tomorrow and some of whom I understand are here today to be available. It is very difficult for them, too. The time is too close to the finish, because too many of us are subject to call. I have a number of bills I must watch and we have a meeting this afternoon of the Labor Committee in this room so we could not continue here and tomorrow I have to appear at another committee meeting on another matter that is very important, so it would be very difficult to continue with these hearings. I wish to say that I am very much interested in your testimony and the experience you have had in developing this legislation. I think I can say for my colleagues that we deeply appreciate your coming here, and as the chairman of the committee I am very sorry we were not able to get through. I thought when we asked you to come that we would get through in 1 day. I am sorry for that and I hope it is not too great an inconvenience.

Senator MURRAY. Inasmuch as a number of documents and statements have been intoduced into this record, emanating from Marjorie Shearon, which we consider to be untrue and misrepresentations and——

Senator DONNELL. Does the Senator yield? The word "we" does not apply to this member of the committee.

Senator MURRAY. I am speaking of myself and the sponsors of the bill—that we consider as intended to confuse the issues and befuddle the minds of the people with reference to this proposed legislation. That material has gone into the record. We consider it false; we consider it nothing but propaganda intended for the purpose of misrepresenting the truth and the facts. Now that is in the record and it seems to me that we should not end this case at this moment with all that in the record unanswered or unrebutted in any way, and I would like to ask the witness if he has any documents which should be introduced in the record which would have a tendency to explain these documents introduced or emanating from Marjorie Shearon.

Senator DONNELL. Mr. Chairman, I would object to the witness answering the question or putting in documents that he himself may conclude to have some bearing on the matter without any opportunity here for cros-examination or examination.

Senator MURRAY. Will you tell us what documents you have?

Senator DONNELL. I should think the matter should go over until January and when this matter comes up he will bring everything in the world that he has and he will be examined fully.

Senator MURRAY. In the meantime, the case goes out to the public generally with the material which has been introduced here during the course of the hearings which we feel totally misrepresents the truth in this matter, and it seems to me that if we have some material here that would answer that, that we should have the right to put it into the record at this time so that it would have such effect as would be proper to offset the false statements.

Senator SMITH. If we are going to adjourn, I don't see how we can let anything come in that we haven't had a hearing on. I would have to rule that we cannot do this. There isn't any publicity on it. This is an adjourned meeting, as though the next witness were tomorrow. We are not going to print and broadcast this day's proceedings until we return.

Senator MURRAY. No; but you have Mrs. Marjorie Shearon here who has organized a propaganda bureau here.

Senator SMITH. She is not doing this for the committee.

Senator MURRAY. She is occupying an office in the Senate Office Building furnished by the Government, from which she sends out literature and material every day falsifying the facts with reference to this—and she admits that she is a propagandist and that she is a lobbyist and has applied for a license to be a lobbyist here.

Mr. FALK. Mr. Chairman, may I ask a question?

Senator SMITH. You may, indeed.

Mr. FALK. It is my understanding that the transcript of these hearings will be printed and become public documents. The members of the committee have already introduced the document referred to as the "Mrs. Shearon Blueprint for the Nationalization of Medicine" which is in a very large measure a personal and what I regard as a malicious and unfair and untruthful attack on me.

If the chairman would permit, I should esteem it a fair opportunity to be given to me, since her document has been placed in the record, if some notes which I prepared on that document of hers and on two other articles, one of which is signed by her and the other one of which is ascribed to her, so that just as her blueprint has not been cross-examined or been subjected to cross-examination and is introduced in the record there will similarly be introduced in the record some comments of mine on her document.

Senator SMITH. How extensive are your comments?

Mr. FALK. A memorandum, which is notes on her blueprint, is on 16 and a fraction typewritten pages; a memorandum on an article in the magazine Medical Economics, November 1945, is on 17 typewritten pages double-spaced; another memorandum on a article signed by her which appeared in Medical Economics of July 1946 is on 2 pages.

Senator DONNELL. I have no objection to the suggestion of the Senator from Montana. It is all right. But as to having these documents in at this time, we would like to cross-examine.

Senator SMITH. We will accept the statement and then we will resume in January.

Mr. FALK. I think that is due me since her attacks bearing directly on me as well as on others and on the legislation before this committee and other bills have been introduced in the record at one point or another. Then in fairness some of my comments upon those documents—and my comments are in a sense part of my defense against charges laid against me and what I regard as misrepresentations, misinformation and so on—will also be of record in the same public record.

Senator DONNELL. No objection on my part.

Senator SMITH. We will order that done. And would you like to have those appear at the place in the record where this phamphlet appears or right in connection with your testimony now, or what would be your preference?

Mr. FALK. I think that the memorandum which deals directly and specifically with Mrs. Shearon's document, the Blueprint for the Nationalization of Medicine, might most properly appear directly with the printing of that document

Senator SMITH. It is so ordered, at your request, at the same place where that appears.

Mr. FALK. And the other two, if I may say so, I think might go in at the same point or at this point in the testimony, as the chairman sees fit. It might be better perhaps, if I may suggest this, to have it follow directly after the document which I referred to as Notes on the Blueprint for the Nationalization of Medicine.

Senator DONNELL. Mr. Chairman, it is my information that the paper to which Mr. Falk refers has not actually been placed in the record as yet. What is your second one you are referring to there, Mr. Falk?

Mr. FALK. The second one I referred to was an article in Medical Economics July 1946.

Senator DONNELL. No. It is the other one.

Mr. FALK. The other one is an article entitled "Labor's Program to Socialize Medicine Internationally—Wagner Bill Revealed as a Product of the International Labor Organization," appearing in Medical Economics November 1945. And it is my recollection that it was included in the transcript either of these hearings or the hearings on S. 1606 last year.

Senator DONNELL. Mr. Chairman, I have no recollection of that, and Dr. Shearon has had nothing to do with this article whatever. It was objected to when it was offered here last year and when it was offered at this hearing my information is, from Dr. Shearon, that it was objected to and not placed in the record. As far as I am concerned, there is objection to putting this in if he wants to put it in.

Senator SMITH. Is the document you refer to your comments on this article or the article itself?

Mr. FALK. It comments on the article.

Senator DONNELL. You are going to put the article in, too?

Senator SMITH. We would have to put it in. Would you rather put them both in or leave them both out?

Senator DONNELL. No objection to both of them going in.

Senator MURRAY. I have no objection.

Senator SMITH. Let's put them both in the record.

Mr. FALK. I suggest that they both be introduced in the record. The article has been used extensively in these connections with the legislation under consideration.

Senator MURRAY. And it has been given wide publicity.

Mr. FALK. Oh, yes. It has been reprinted and the reprints widely distributed.

Senator SMITH. I would suggest that that article and your comments appear in the record in connection with this colloquy we are having now so it will be understood why we are putting it in, and these are put in at your request, Mr. Falk, to clarify your position with regard to the points made in this article.

Senator DONNELL. I want the record to show that my understanding is that Dr. Shearon had no connection whatsoever with the article Labor's Program To Socialize Medicine Internationally. She had no connection, so I am told by her, with the article, and I believe that to be correct—if we are talking about the same article.

Mr. FALK. Yes, sir. In my notes, I might say for the record, Senator, is included a reference to an ascription of that article to her in a publication put out by the National Physicians' Committee. There are, I have presumed, internal evidences in this article that she had something to do with its preparation. It is so widely reported.

Senator DONNELL. I do not recall it by name but I recall seeing in one of the publications of the National Physicians' Committee that an article had by mistake been ascribed to Dr. Shearon, and it was corrected in a subsequent issue of this publication to which the witness refers. It was pointed out that Dr. Shearon had nothing to do with it. There is no objection to both of them going in.

Senator MURRAY. Do I understand that Mrs. Shearon repudiates the article?

Senator DONNELL. She had nothing to do with the article. It is not a matter of repudiating it.

Senator MURRAY. It has been ascribed to her and she has been the chief propagandist against this bill and has diffused her propaganda widely throughout the country, and it seems to me it is along the same line and it ought to be explained at the same time.

Senator DONNELL. Mr. Chairman, she has diffused light on this in other respects.

There is no objection to its going in but she had no connection with it.

(The article referred to appears on p. 1773.)

Mr. FALK. Mr. Chairman, may I ask whether in addition to this statement which Senator Donnell has made for the record the chairman might also obtain for the record a report on the authorship of that article from the publishers, as to who participated in preparing the underlying documents for it if that is different from who prepared the final printing of it.

Senator DONNELL. I understand that one Hazel Huffman, now with the House committee, wrote the article in question and Dr. Shearon had nothing whatsoever to do with the preparation of it.

Senator MURRAY. There would be no objection to your taking the matter up with the publishers and making inquiries and furnishing us with any information you may develop.

Mr. FALK. My position, Senator, is that since matters contained in that article, many of which are plainly and clearly erroneous and misrepresent the facts, have been utilized extensively by Mrs. Shearon in her "Blueprint" and in documents which repute to be recordings or summaries of speeches which she has made, I was prepared mentally to accept the statement which appeared in the document issued by the National Physicians' Committee ascribing the article to her, and to accept other reports that she was the reputed author.

Senator DONNELL. Did you see the subsequent statement by the National Physicians' Committee in which it pointed out that the ascription of this document to her was in error and that she didn't write it?

Mr. FALK. I have seen the errata slip which was pasted in and which was not altogether unambiguous as I read it. It says that they made a mistake in giving a footnote in which they mention her name as the author because it is a fact that the original article did not have the author's name. I was not sure when I read the errata slip whether they were saying merely that they had made that mistake or whether they were saying she had not written the article.

Senator DONNELL. Do you have the errata slip with you?

Mr. FALK. No. I am sorry I haven't.

Senator DONNELL. May I ask you why you didn't mention to us this errata slip when you told us you wanted to offer this article by her? You knew very well, did you not, that the National Physicians' Committee had called attention with an errata slip to the fact that there was an error in ascribing this article to Mrs. Shearon, and yet you wanted to introduce the document into this record. Why didn't you tell us about it?

Mr. FALK. In some of the copies they had this errata slip, in some they had not.

Senator DONNELL. So you have heard it discussed quite a bit. You knew it was in some copies, didn't you?

Mr. FALK. Yes, sir. My reason for introducing it had nothing to do with that. I gave my reasons. I said that document had been used extensively, and I believe I am justified in saying by Mrs. Shearon, in the Blueprint as well as elsewhere, and that I was bringing this up as well as the other article which bears her signature in the magazine Medical Economics as well as my notes on the Blueprint for those reasons.

Senator DONNELL. I didn't understand and do not recall that the reason you were introducing that labor article was that it was referred to in a subsequent article by her. I understood you were referring to the article, and all the time you knew the National Physicians' Committee had by an errata slip called attention to the fact that the ascription was erroneous, and yet you didn't call the committee's attention to it.

Mr. FALK. I am sorry, you are misinterpreting what I said. What I intended to say in this reference to these two other articles, as I believe the record will show, was in connection with the Blueprint. There are many places where the same material in substance is used one way or another, in respect of the International Labor Office, legislation here before this Congress, to the alleged participation of these other persons in the International Labor Office. It is on that basis that I connected that article as well as the other article in Medical Economics to the Blueprint. I do refer to the fact that there have been reasons for believing that Mrs. Shearon had something to do with the Medical Economics article, the one that has no authorship. I might be mistaken about the authorship, though I had not thought I was. I am confident that I am justified in saying that the utilization of that article, whether by reference or not, in the Blueprint connects it with the Blueprint in no uncertain fashion.

Senator DONNELL. I would like to have the record show that the errata slip was issued by the National Physicians' Committee, also that this committee, the National Physicians' Committee, later put out an edition without Mrs. Shearon's name or an errata slip and that they reprinted that particular page of that publication. I will ask, Mr. Chairman, that you request the clerk of this committee to secure from the National Physicians' Committee a complete list of publications with the articles and errata slips and so forth, everything that pertains to that particular article that is in the possession of the National Physicians' Committee.

(The publications referred are on file with the committee.)

Senator SMITH. I think that is a proper request if we are putting these documents in the record.

Mr. FALK. May I add, Mr. Chairman, that the notes to which I referred have a footnote which says:

> An errata slip pasted into some of their copies says: "Pages 15 to 18. Credit for authorship of the article Labor's Effort to Socialize Medicine Internationally is erroneously given to Dr. Marjorie Shearon. The article appeared unsigned in Medical Economics, November 1945."

Senator DONNELL. Is there any ambiguity in that, as far as you can see, in regard to making it perfectly clear that the National Physicians' Committee is saying it was a mistake that she had been charged with being the author of that article? Is there any ambiguity there?

Mr. FALK. It doesn't say she didn't write it. It says the article appeared unsigned in Medical Economics November 1945.

Senator DONNELL. What does it say just before that?

Mr. FALK. "Pages 15 to 18 * * * Credit for authorship of the article Labor's Effort to Socialize Medicine Internationally is erroneously given to Dr. Marjorie Shearon."

Senator DONNELL. What do you understand by that? What does that mean?

Mr. FALK. I am not sure what it means.

Senator MURRAY. Mr. Chairman, I think that means that she made a mistake in stating in public the fact that she was the author. They do not deny that she was the author, but they merely say it was a mistake to put that in the record as coming from her.

Senator DONNELL. If that is the kind of reasoning on which S. 1320 is based, we will rest our case right here. That is as thin a piece of reasoning as it has been my opportunity to hear here or anywhere else in the Senate so far.

I want the record to show now that Dr. Shearon denies that she is the author of that article, and I want the record to show that the chairman has agreed that he will have the clerk of this committee request the National Physicians' Committee for the errata slip and the various publications of that particular article so we will have the full facts before us.

Senator MURRAY. Mistakes of that kind occur very frequently. It probably was intended that her name was not to be connected with it at the time they gave it out for publication. A mistake was made and they connected her name with it.

Are you familiar with the National Physicians' Committee? Do you know what that organization is?

Mr. FALK. I know a little about it. I wouldn't say I was familiar with it. I have seen some of their publications and some of their documents, and I have seen reports on them.

Senator MURRAY. Isn't it engaged in carrying on propaganda somewhat similar to the propaganda being carried on by Majorie Shearon?

Mr. FALK. Similar, yes, sir, in many respects. It has been more directed at bills or proposals and bills than at personalities and individuals and people than have Mrs. Shearon's, I would say as my judgment, but otherwise it has many similarities.

Senator MURRAY. Doesn't it misrepresent the truth in connection with proposed legislation?

Mr. FALK. I would give it as my opinion, sir, that it does.

(The materials for which Dr. Falk obtained permission for insertion in the record are as follows:)

LABOR'S PROGRAM TO SOCIALIZE MEDICINE INTERNATIONALLY

WAGNER BILL REVEALED AS A PRODUCT OF THE INTERNATIONAL LABOUR ORGANISATION

[This is without doubt one of the most important articles published by Medical Economics in recent years. It is important because it explains for the first time in any periodical the "master plan" of the International Labour Organization for socializing medicine in all countries of the world. No pipe-dream, this plan is already responsible for the establishment of state medicine in Chile and in New Zealand. Still more significant—though not generally known—is the fact that the Wagner-Murray-Dingell bill in this country was written largely by ILO leaders and that those same leaders are a powerful element in the current campaign for its passage. Information on which the article is based was secured by, and under the direction of, a special investigator who has conducted inquiries for many congressional committees and has had extensive experience with medical-care issues. The investigation consumed a full three months. Literally scores of sources were interviewed. Three cases of documents were collected. Every fact was checked and authenticated. The result is a story calculated to open the eyes of every physician and every thinking layman who reads it. Copies are being released to all leading newspaper, radio, and magazine editors; Congressmen, Governors, and professional assosiations.]

The Wagner-Murray-Dingell bill (S. 1050) should not be considered an American-made piece of legislation. It is merely the latest action taken by a member state of the International Labour Organisation, in this instance the United States.

It is commonly believed that certain Senators and Representatives have sensed a public demand for the socialization of medicine and have drafted legislation to provide it. This is at best a half-truth. The majority of the American people have made no such demand. Those behind it are leaders in the labor movement in this country and abroad.

A good many people associate legislation to socialize medicine with the advent of the New Deal. But in this sphere, Franklin D. Roosevelt was no innovator; he was a follower. Plans for socializing medicine throughout the world—one nation at a time—had been drawn up by the International Labour Organization years before. Mr. Roosevelt was merely the agent who, it was hoped, would implement ILO aims in the United States. He made a good start.

But what is the ILO? How did it originate? When did this country become involved with it? What is it trying to do? How does it operate? What practical significance does it have for U. S. physicians?

The International Labour Organisation began as a private agency with headquarters in Basel, Switzerland. In 1919, under Part XIII of the Versailles Treaty, it achieved official status as a subsidiary of the League of Nations. Its main office, up until World War II, was in Geneva; now it is in Montreal. Branches are maintained in Washington, D. C., and in other major capitals.

Original founders of the ILO were the International Association for Labor Legislation and its various national affiliates (e. g., the American Association for Labor Legislation). Other international organizations, with interlocking directorates, lent needed assistance; among these was the International Association for Social Security, which openly advocated the socialization of all phases of human endeavor.

The U. S. Senate, in 1919, specifically withheld the assent of the United States from Part XIII of the Versailles Treaty. Senators at that time were aware of the operation of organizations such as the International Association for Labor Legislation and the International Association for Social Security. They knew that Samuel Gompers, president of the American Federation of Labor, had withdrawn from the American Association for Labor Legislation and had denounced its objectives as un-American. Despite Senatorial skepticism about ILO aims, however, the first officially approved International Labour Conference was held in the Navy Building at Washington, D. C., that same year. Franklin D. Roosevelt, then Under Secretary of the Navy, made the necessary arrangements for the meeting.

From 1919 until 1934 U. S. participation in the International Labour Conference was through unofficial observers. These observers were among the strategists and labor leaders responsible for the creation of the ILO. World socialization was their aim, socialized medicine being only a small factor in their plans at that time.

In 1934, through an unheralded joint resolution, passed by Congress, the United States became a "Member State" of the International Labour Organisation and accepted the ILO constitution. But only a small segment of the public knew about it.

Nor did many realize, as stated in the resolution, that the United States "took part of 1900 in establishing and for many years thereafter supported the International Association for Labor Legislation." Thus, world planning for compulsory social insurance is directed by the ILO with the approval of the governing but usually without the knowledge of the governed.

The International Labour Organisation states its purpose as being "to promote social justice in all the countries of the world. To this end it collects facts about labour and social conditions, formulates minimum international standards, and supervises their national application." In seeking to supervise the national application of ILO standards, the ILO is obviously more than a mere fact-finding group.

The Governing Body of the ILO is composed of sixteen government representatives, eight representatives of management, and eight representatives of labor. "By accepting the Constitution of the International Labour Organisation the States [national governments] agree to the preparation of international rules for social insurance by a permanent body . . . of experts in social matters, namely the International Labour Office, and to the elaboration of these rules by a permanent congress, namely the International Labour Conference, consisting of representatives, not only of governments, but also of the classes directly concerned, capital and labour."[1]

The International Labour Office acts as a secretariat, an information center, and a publishing house. It is "staffed by experts drawn from many different countries, whose knowledge, experience, and advice are available to all the nations which are members of the Organisation. It has branch offices and correspondents in many countries."

What Americans serve among these experts? For medical care planning, there are at least three (none of them physicians): Arthur J. Altmeyer, chairman of the Social Security Board; Isidore S. Falk, director of the SSB's Bureau of Research and Statistics; and Wilbur Cohen, its assistant director.

The International Labour Conference is described as "a world parliament for labour and social questions." Each national delegation to the annual meetings comprises four delegates, two representing the nation's government, one representing management, and one representing labor; each of these three sections "speaks and votes independently, so that all points of view find full expression."

The U. S. Government, like others, pays the expenses of its own delegates to the annual conferences. In addition, it pays dues to the ILO as a member state.

Few people have any conception of the influence the International Labour Organisation exercises on their daily lives. A hint of this influence was given by Franklin D. Roosevelt in an address before ILO delegates on November 7, 1941. He credited the ILO with "shortening the hours of labor, protecting women and children in agriculture and industry, making life more bearable for the merchant seamen, and keeping the factories and mines of the world more safe and fit places for human beings to work in." He added that "Through the long years of depression, from 1929 on, it sought to bring about a measure of security to all workers by the establishment of things like unemployment insurance and old-age insurance systems. Again, it sought to set the wheels of industry in action through etablishment of international public works, rational policies of migration of workers, and the opening of the channels of world trade."

The late President did not in that address mention the efforts made by the ILO to promote socialized medicine. He neglected to say that the ILO had included requirements relating to medical care in its Workmen's Compensation Convention of 1925 and in its Sickness Insurance Convention and Agricultural Convention of 1927. He omitted any reference to ILO work on public health and health insurance in periods of economic depression on the economical administration of medical and pharmaceutical benefits under sickness insurance schemes, and on curative and preventive care for invalids, the superannuated, and widows and orphans.

These activities were small steps toward the larger goal. By means of them, doctors and patients would become accustomed to socialized medicine in its milder forms.

In 1943 and 1944 the ILO put finishing touches on 114 proposals for the "improvement and unification of medical care services." Many of these are embodied in the Wagner-Murray-Dingell bill (S. 1050) and in other proposals for social legislation.

The amount of effort being expended by the ILO in furthering these proposals is suggested by the size of the organization's 1945 budget, which is $2,702,655, or double the 1944 figure.

Following is the procedure used by the ILO to effect legislation among its member states:

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[1] Provisional Bulletin No. 5, Inter-American Committee on Social Security (ILO), p. 29.

The Governing Body or the International Labour Conference itself, by a two-thirds majority vote, makes certain Recommendations. These are discussed and refined in a series of Consultations. The Recommendations then receive a vote by the Conference. A two-thirds majority vote by the delegates present means acceptance. The Recommendations then become Draft Conventions, and copies of them are sent to every ILO member state. Such members—*e. g.*, the United States—must bring the Draft Conventions before their legislatures within a year.

Nor does ILO authority cease there. Governments are bound by agreement to submit annual reports to the ILO, showing how ILO proposals have been acted upon.

Seven important Recommendations (including one on medical care) were adopted at the International Labour Conference held in Philadelphia from April 20 to May 1, 1944. Said President Roosevelt then:

"Under the constitution of the International Labour Organisation, these recommendations are forwarded to the member Governments for submission by them to their respective, competent national authorities. I shall accordingly submit them to the Congress in the regular way when certified copies are received."

In some instances ILO Draft Conventions have been presented to our Congress in their original form and wording. In other cases they have been rewritten in a form deemed more likely to enlist support (*e. g.*, the Wagner-Murray-Dingell bill).

Chairman of the ILO Governing Body at the present time is U. S. Delegate Carter Goodrich. Other U. S. members of the Governing Body include Henry Harriman, representing management, and Robert J. Watt, representing labor.

An ILO subcommittee on medical care has been active for a number of years. When it met in 1943, there was discussion of a proposal "that all medical care services shall be regulated by law." Dr. J. J. Heagerty, Canada's Director of Public Health Services, asked what exactly was meant by the words "regulated by law." He wanted to know whether they meant that the actual rendering of medical treatment by physicians would be government-controlled.

Miss Laura Bodmer, of the ILO staff, indicated that it would. She also volunteered the opinion that private, voluntary insurance would be wiped out.

Isidore Falk, one of the American representatives present, suggested that in place of the word "regulated" a more "desirable" term be used. The provision that "medical care services shall be regulated by law" was therefore changed to read: "The nature and extent of the care provided by the service shall be defined by law."

By such careful concealment of purpose, ILO strategists hope to convince the American people and their elected representatives of the virtues of national socialism.

Of particular significance to the medical and allied professions is the International Labour Conference held in Philadelphia in 1944. At that session delegates[2] adopted a medical care recommendation embracing 114 detailed proposals to guide the member states in developing their health services. A majority of the 114 proposals are embodied directly or by implication in the Wagner-Murray-Dingell bill of 1945 (S. 1050).

The ILO medical program would relegate physicians to the role of mere functionaries. Under wage-and-hour legislation, they would be classed simply as skilled workers. Private practice would be frowned upon. All medical services would be regulated by law. Administration would be a central government agency with the help of unified local agencies.

One recommendation calls for the "establishment of chairs of social medicine" in medical schools. Students would thus be available for indoctrination in the principles of socialism before starting practice.

The ILO urges that "health protection be organized on the basis of national insurance applied to wage earners and their families and to the self-employed * * * this insurance should cover medical, surgical, pharmaceutical, hospital, dental, prosthetic, and cash benefits."

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[2] The U. S. delegation was composed of the following persons (none of them physicians) representing the groups specified:

Government—Senator Elbert D. Thomas (D., Utah), delegate; Assistant Secretary of State Adolphe A. Berle, Jr., substitute delegate for Miss Frances Perkins, the official delegate; Frieda S. Miller, Otis E. Mulliken, Charles W. Taussig, A. Ford Hinrichs, and Isador Lubin, advisers.

Management—Henry I. Harriman, former president, U. S. Chamber of Commerce, delegate; Henry S. Dennison, Charles Redding, and Clarence G. McDavitt, advisers.

Labor—Robert J. Watt, American Federation of Labor, delegate; William Green, president, American Federation of Labor, adviser; George Meany, adviser.

Drastic limitations on physicians' dispensing and prescribing and on the pharmaceutical industry are specified in regulations proposed by the ILO. For example:

"In several countries pocket books have been issued which show, for the different medicines, the most economical composition, dosage, form, and method of dispensing. It is desirable that these pocket books be widely used in order that practitioners should have at their disposal detailed information enabling them to compare the prices of remedies, according to the ingredients of which they are compounded and to the form in which they are prepared (pills, solutions, tablets, cachets).

"These pocket books, which have been found most useful to the practitioners, specify certain medicines as being economical, without, however, implying that those not mentioned are uneconomical or are never to be prescribed * * * Preparations of particular make should be ordered only if no substitutes of equal therapeutic value exist or if they cost no more than substitutes dispensed from the practitioner's prescription * * * Preparations sold under trade-mark should, where possible, be prescribed under their scientific designation.

Related proposals which have been formally approved by the ILO follow:

"To prescribe unnecessary drugs or treatment does the patient no good and is a source of loss to the fund. Therefore it should be made legally compulsory for the doctor to follow the rules for economical treatment, in the interest both of the social insurance scheme and of the nation as a whole. The rules should give practical hints on treatment which will give the best results at the lowest cost. When two methods are of equal value, the doctor must choose the more economical * * * The rules should be drawn up be representatives of the fund and of the doctors, with the help of expert pharmacists * * * Patent medicines should as a rule not be prescribed unless no substitute can be made up more cheaply from the pharmacopoeia. Patent or proprietary medicines which have not been sufficiently tested or which merely contain well-known drugs in a new wrapping of whose composition is unknown should be excluded from use in social insurance. Since there are, however, proprietary medicines which have great therapeutic value and cannot be replaced, governments should see that they are not sold at excessive prices * * *

"No satisfactory solution of the problem of proprietary medicines can be reached until the official pharmacopoeias have been entirely and radically revised and the manufacture of drugs put under systematic supervision." (Placing the manufacture of drugs under government control would be altogether logical to the ILO, inasmuch as the government would be the sole purchaser.)

Development of social security (including socialized medicine), under international administration is a leading ILO goal. The program promotes depoliticalization wherever political control can be superseded by administrative control. This effort, if successful, would tend to remove authority from Congress and other law-making bodies and supplant it with administrative control by an international bureaucracy. It would be a radical departure from the current program, which stops at the national level.

Proposals for an international health organization have been made as recently as August 1, 1945, when S. J. Res. 89 was introduced in our own Congress by Senators Pepper, Wagner, Murray, Capper, Ball, and Smith. Under this bill socialized medicine would be administered within the framework of the United Nations, with the United States as one region of activity.

The interlocking of national with international groups interested in social reform (including socialized medicine) had its start at the Arbitration Court of the Hague in 1899. This was followed by the formation of several nonofficial international labor groups, among them the International Permanent Committee for Social Security and the International Association for Labor Legislation.

By 1913, various foundations (Russell Sage, Milbank, Rosenwald, Rockefeller, and others) also began to concern themselves with social insurance. They sent representatives to participate in the conferences of all the major international labor associations. One of the most important factors in the field by 1915 was the Carnegie Foundation and its director, Dr. James T. Shotwell.

Not infrequently, private organizations sponsored by foundations and dedicated to the furtherance of ILO aims are taken over by the Government and given the status of Federal agencies or are reorganized as pressure groups. The Committee on the Costs of Medical Care is an example.

According to Phillips Bradley, chairman of the Department of Political Science at Queens College, New York, in 1942, the number of private international organizations today exceeds 700. "They cover practically every 'interest'—economic and social, individual and group. They cut across state [national] frontiers and include individual members or functional associations in several, or many, states [nations]. * * * Direct government support and participation are not uncommon. Some of these organizations are composed of groups of governmental employes though not officially sponsored by the governments themselves.

"These organizations correspond, in the international sphere, roughly to pressure groups in the domestic. * * * As they develop the visible evidences of cooperation through conferences and other collaborative activities and agencies, they tend to break down barriers to common official action. * * * More than one, originating in purely unofficial activities, has become the nucleus of official international cooperation at the administrative level.

"Illustrations of this type of development are numerous. First, there appears an organized effort to bring together individuals and groups in different states [nations] concerned with the promotion of improved conditions or uniform standards. Conferences are organized. Governments sooner or later send 'observers.' Gradually, as public policy is brought into line with the objectives of these associations, governmental representatives participate officially in the conferences. Finally, interested governments associate themselves actively in the management and activities of these organizations, or take them over as official agencies of cooperation. Thus the cycle is completed and the area of official international administration is widened.

"No brief analysis can do justice to a movement as significant as the development of international administration over the past century and a quarter. * * * The process of depoliticalization is only begun. But we have achieved in the time both the framework of efficient organization and the means for effective collaboration among the civil servants of an integrated international order."

When United States Government officials meet with those of other nations for the purpose of collaboration and exchanging ideas, it is assumed that they do so in the interest of the United States. This is not the view taken by the International Labor Organizations. Consider, for example, the following story, told by H. B. Butler, former ILO Director General, about Albert Thomas, the organization's first Director General and a leading French Socialist:

"He [Albert Thomas] regarded himself, and insisted vigorously that every member of the staff should regard himself, as an international official—not as the servant of his own government or the defender of his country's interests. On one occasion a volcanic outburst was provoked by a request for permission to leave the Office because the government of the official in question thought he could further the national interest better elsewhere. The Director flared out: 'What are national interests? They are something that I know nothing about in this Office and which I refuse to consider. If you cannot be an international official you had better go.'"

This same concept of "internationalism first" is revealed in the platform of the Food and Agriculture Organization of the United Nations, publicized this past summer. That it will characterize also the other staffs of the United Nations organization—including the Health Section under the Economic and Social Council—is generally presupposed.

Certain United States Government officials who participated in ILO operations may be asked one of these days to indicate just where their interests lie. This applies to several in the Social Security Board (referred to at times as an "ILO subsidiary").

When the Social Security Board was originally being set up, members of the ILO staff were called to Washington to help direct the effort. They have gone also to Ottawa to aid the revision of the Canadian unemployment system, to London to give expert testimony before the Beveridge committee, and to a number of the Latin-American countries to supervise the creation or revision of their social-security plans.

John G. Winant, U. S. Ambassador to Great Britain and former Governor of New Hampshire, was the first Chairman of the Social Security Board (1935–37). Both before and after his SSB connection he served the International Labour Office, first as Assistant Director, later (1939) as Director General.

Carter Goodrich, economist and professor of economics at Columbia University, was with the Social Security Board in 1937. Mr. Goodrich served as a member of the ILO Governing Body from 1936 until 1939 when he was made chairman. He still holds that office.

Former U. S. Secretary of Labor Frances Perkins has been considered by ILO heads for the post (currently unfilled) of Director General at $20,000 a year, plus expenses. The Acting Director General is Edward J. Phelan.

Three Social Security Board officials recently away from their desks attending ILO conferences were Arthur J. Altmeyer, SSB chairman; Isidore S. Falk, director of SSB's Bureau of Research and Statistics; and Wilbur Cohen, the bureau's assistant director. Mr. Altmeyer was in Mexico City from July 23 to July 30, 1945, attending the Conference of the Inter-American Committee on Social Security (ILO), of which he is chairman. Mr. Falk, at the same time, was in London, attending the ILO's Maritime Commission Conference. Mr. Cohen was at the Inter-American Conference in Mexico City with Mr. Altmeyer; he had previously been one of the "experts" at the ILO Social Security Consultation on Income Maintenance and Medical Care, in Montreal.

When the ILO transferred its office from Geneva to Montreal, it retained only a skeleton staff at the new location. A number of ILO employes thereupon were placed on the Social Security Board pay roll. Part of their work (like that of many SSB employes) is the prepartion of material to be used by U. S. officials at ILO conferences.

The Social Security Board is by no means the only U. S. Government agency participating in ILO activities. Another important one of interest to physicians was the National Resources Planning Board, active up until a year ago. This bureau, charged with "the study of the social and economic needs of the postwar world," was influenced in no small degree by the ILO philosophy. Its reports on medical care were widely read by physicians.

Examples such as this demonstrate clearly that no large-scale study of socialized medicine can be made without giving thought to the role played—and to be played—by the ILO. Its importance is emphasized still further by the fact that the ILO has been promised a key role in the Economic and Social Council of the United Nations. (Assurance to this end was given by the late President Roosevelt in 1944 and by former Secretary of Labor Frances Perkins on June 22, 1945.)

It is significant that representatives of six international organizations (the League of Nations, the United Nations Interim Commission on Food and Agriculture, the United Nations Relief and Rehabilitation Administration, the Intergovernmental Committee on Refugees, the Pan American Union, and the Pan American Sanitary Bureau) were on the platform, with Mr. Carter Goodrich, at the opening of the International Labour Conference in Philadelphia in 1944.

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Thus has organized labor been striving for the past several decades to foist socialized medicine on the American public. Other countries have succumbed. Will the United States?

Current proposals for extension of the Social Security Act and for the creation of a system of Federal medicine are evidences of the current strategy. In the meantime, the American public, generally, is quite unaware that a planned economic revolution is taking place, with socialized medicine an important factor.

From Bismarck to Wagner, the plan of the socializers has differed from the Communist ideal in only one aspect. Under communism, the state owns everything and is the employer of the worker, be he doctor, nurse, or patient. Under socialism, the state finances, regulates, and administers the program.

Almost every phase of the Bismarck-Wagner program has already been translated into American law as social security (workmen's compensation, unemployment insurance, old-age pensions, wage-and-hour regulations). Should compulsory sickness insurance come to pass, we will have completed the pattern. All members of the community, whether or not gainfully employed, will then receive their medical care under government direction.

No one in medicine and in its allied fields will be free from the administrative yoke. For the care afforded will comprise "both general practitioner and specialist out- and in-patient care, including domiciliary visiting; dental care; nursing care at home or in hospital or other medical institutions; the care given by qualified midwives and other maternity services at home or in hospital; maintenance in hospitals, convalescent homes, sanatoria, or other medical institutions; so far as possible, the requisite dental, pharmaceutical and other medical or surgical supplies, including artificial limbs; and the care furnished by such other professions as may at any time be legally recognized as belonging to the allied professions."

There will be no market except the Government.

"LABOR'S PROGRAM TO SOCIALIZE MEDICINE INTERNATIONALLY—WAGNER BILL REVEALED AS A PRODUCT OF THE INTERNATIONAL LABOR ORGANIZATION"—MEDICAL ECONOMICS, NOVEMBER 1945"

In advance of the hearings on July 23, 1947, I prepared notes to furnish a basis for oral comments since I expected that questions would be raised concerning Mrs. Shearon's "Blueprint" pamphlet and the two articles published by the magazine Medical Economics in the November 1945 and the July 1946 issues. These notes are introduced at this point in the record by permission of the subcommittee. —I. S. FALK.

1. (*Pages 1773–1774*).—The author of the article ("special investigator"), though anonymous, was identified in the pamphlet Compulsion—The Key to Collectivism published in 1946 by the National Physicians Committee.[1]

It is said in the box "Every fact was checked and authenticated." As will be evident, the whole article is a fraud, woven out of a mixture of fact, fancy, and fabrication.

2. From the title on it uses the Fishbein technique of labeling the Wagner-Murray-Dingell bill and health insurance as "socialized medicine." This well-known technique is here carried to the "big lie" stage. Where formerly socialized medicine was labeled a national plot or conspiracy, here it is converted into an international plot, with the ILO as the villain in the piece, and with all who have had an active interest in national health legislation or any working relations with the ILO charged with being part of an international plot. Those behind the movement for socialized medicine in the United States are here referred to as leaders in the labor movement in this country and abroad (p. 36, column 1).

3. *Page 36, column 2.*—Never heard before of the International Association for Labor Legislation, International Association for Social Security, with interlocking directorates * * * which openly advocated the socialization of all phases of human endeavor.

Later I wrote to Mrs. John B. Andrews. The following is from her reply (letter of October 20, 1946):

"(1) This paragraph is hopelessly confused. It was of course our International Association that had headquarters in Basel beginning about 1900. The ILO was not organized until 1919.

"(2) Our International Association had nothing official to do with the founding of the ILO and the American section was in no way connected with the foundation. After the ILO was authorized by the League of Nations, John [B. Andrews] was a representative of our Government at its organization meeting in London in 1919.

"The name of the committee to which they probably refer was the International Committee for Social Insurance formed in 1889. I'm sure it had no official connection with the organization of the ILO and of course it did not advocate 'the socialization of all phases of human endeavor'."

4. *Pages 1724, seventh full paragraph*).—Re Gompers withdrawal from AALL. Did it ever happen? What about A. F. of L. membership on that organization up to its termination in the 1940's? I didn't know, so I asked Mrs. Andrews and received the following reply: "(3) Sam Gompers did resign from our association around 1918–1919 in protest over our health insurance campaign. But Gompers' stand was repudiated by the New York State Federation of Labor which supported our work. Gompers, as you well know, opposed *all* the social insurance. He was, however, labor representative of the official United States organizing group at Paris in 1919."

The play here on Mr. Samuel Gompers and his alleged position in 1919 must seem strange to anyone familiar with the fact that ever since the United States became a member of the ILO an A. F. of L. officer has been the American labor representative to the ILO, and with the fact that the A. F. of L. has so vigorously insisted on this representation that they have even refused to share or alternate it with the CIO. (The ILO constitution provides for government, employer, and labor delegates, with the employer and labor delegates chosen "in agreement with the industrial organizations * * * which are most representative of employers or work people, as the case may be."

5. Here is as good a place as any to make some general remarks about the plain attempt of this article to make the ILO appear to be something very different from what it always has been and is. With apparently malicious intent, the article

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[1] An errata slip pasted into some of their copies says: "Pages 15 to 18. * * * Credit for authorship of the article Labor's Efforts To Socialize Medicine Internationally is erroneously given to Dr. Marjorie Shearon. The article appeared unsigned in Medical Economics, November 1945."

puts bits and pieces together to make the ILO seem to be a world socializing or communizing organization. Yet every informed person knows it was and is an organization which has striven for world progress and international agreements through peaceful, orderly, and reasonable methods which have the fullest regard for the independence, strength, and dignity of the national policies and the national traditions of each nation that is a member. The constitution of the ILO provides that no member nation can be coerced; each has to voluntarily decide for itself whether it agrees to a convention (international treaty) adopted by the ILO. (Note that of the scores of conventions adopted by the ILO in its 25 years of existence, only 5 have been ratified by the United States, and all of these deal with international agreements on the maritime industry—an industry in which nations are in direct and continuous competition, where business, labor, and governments jointly have been trying to bring order out of chaos.)

In 1934, though the United States had never joined the League of Nations, it joined the ILO. Why? The ILO was affiliated with the League, but was independent of it. We could join the ILO without ratifying the Versailles Treaty or joining the League. There are many people in the United States who believe we should have joined the League—right after World War I or soon thereafter. Millions of people believe, today, that had we joined the League—even some years after it was organized, we would have had a better chance than we did to help prevent World War II. But whether that is correct or not, it is quite generally agreed that we at least made a sound decision when we joined the ILO in 1934. In fact, the question might be asked who in the United States of any standing in Government, politics, public affairs, business or labor questions the wisdom of our membership in the ILO—other than the author of this article in Medical Economics? And the uninformed who have been persuaded by these misrepresentations in Medical Economics and in other publications? So far as is known, this is a one-person campaign against the ILO, supported by a magazine that is financed mainly by drug and medicine advertisers. Why? Because the anonymous author is spearheading an attack on health-insurance legislation in the United States; and has cooked up an "international plot." From time immemorial demagogues have wrapped themselves in their flags and used attacks on their opponents as a substitute for reasonable arguments. A "foreign threat" has long been useful as a means of turning patriotism and nationalism against a domestic cause. That is obviously the author's technique in the present case.

A reader of this article would never guess, for example, that the United States delegation to the ILO (with Government, employer, and labor membership) for many years included as its employer member the Past-President of the United States Chamber of Commerce.

[For the story of the ILO and its role in working for world progress in economic relations, in striving for peace and improvements in the lot of man everywhere, see The Lost Peace (1942) by Harold Butler who was from 1920 to 1938 first Deputy Director and later Director of the ILO, and who during World War II was Great Britain's Minister to the United States.]

[Note also that the new constitution of the ILO, to bring it into relation with the UN, was approved by the United States Senate unanimously (and this includes Senator Taft specifically) June 2, 1947. See Congressional Record, pp. 6277–8, 6302–7.] [Note that all this is long after the appearance of Mrs. Shearon's Blueprint, etc.]

6. *First picture and legend, Medical Economics, page 38.*—What is there in the 1944 ILO Declaration of Aims, signed by President Roosevelt, Mr. Nash, and Mr. Phelan, that has to do with "A death warrant, they hope, for private medical practice?"

Second picture and legend, Medical Economics, page 39.—What has Harold Laski's demands for nationalization of medicine along with banks, utilities, mines to do with the ILO? There is not a word in the article to tie him up with the ILO. He has nothing to do with the ILO, but his picture and this remark about him are thrown in. Senator Thomas, of Utah, Mr. Goodrich and a remark about Miss Perkins are similarly thrown into this page.

7. *Page 1775, second and third full paragraphs.*—Note that one paragraph starts with a statement about the ILO "staff of experts" and the next paragraph refers to Altmeyer, Falk and Cohen of the Social Security Board after the question "what Americans serve among these experts?" Is the reader expected to get the impression that these three officers of the United States Government are on the staff of the ILO? Of course, the fact is that they are not. They are occasionally consulted as experts by the ILO, just as are thousands of other persons, in many countries, who are in government, management, labor, universities, etc.

8. *Page 1775, paragraphs 6–8.*—Here is a quote from President Roosevelt which refers to some of the great accomplishments that the nations of the world made under the leadership of the ILO. But here it is put in the author's setting merely to suggest to the reader "the influence the ILO exercises on their daily lives" in some malign way. The author goes on to say the President did not mention this and that which the ILO agreements had recommended relating to workmen's compensation, sickness insurance, agreements as to the working conditions of agricultural labor, for the care of aged widows and of orphans, etc. So what? The President—in a general speech—wasn't giving a catalog of all ILO achievements.

The reference to the ILO standards for workmen's compensation is revealing. The author tries to give the impression that the ILO conventions on workmen's compensation are subversive and dangerous because they call for the provision of medical care to injured workers. The author fails to mention that every workmen's compensation law in this country makes similar provision and that no responsible person questions the need for such provision. Even the AMA has gone along on this, and has urged more and better, and better managed, medical care for workmen's compensation cases.

Incidentally, those conventions—to which the author refers and which the President didn't mention—are conventions which the United States of America did not adopt (though some other countries did) and which have never been binding on the United States (though they are on those countries which voluntarily approved them). The author's point is, apparently, merely to condition the reader's mind to think that everything the ILO does has a bearing on and is for the purpose of "socializing medicine." ["These activities were small steps toward the larger goal. By means of them, doctors and patients would become accustomed to socialized medicine in its milder form."] In short, every effort to shorten the hours of labor, to protect women and children in agriculture and industry, to make life more bearable, safer or secure for the merchant seamen, to keep the factories and mines of the world more safe and fit places for human beings to work in (from her F. D. R. quote), all these and many more are "small steps toward the larger goal."

9. *Page 1775, ninth full paragraph.*—The author of the article says that in 1943 and 1944 the ILO "put finishing touches on 114 proposals for the 'improvement anw unification of medical care services.'" And the author of the article says "many of these are embodied in the W–M–D bill (S. 1050—(etc.)." Note that the W–M–D (S. 1050) was merely an amended version of S. 1161 which was actually introduced in Congress on June 3, 1943, before the ILO work and documents of July 1943 and April–May 1944. Someone might ask the author of the article how the ILO "114 proposals" got "embodied" in an American bill that had been introduced before the "114 proposals" even existed.

Also, the reader would never guess that the ILO proposals on medical care (Philadelphia Conference, 1944) were not approved by the United States Government delegates because they disagreed with many of them. (On the final vote on the recommendation concerning medical care, the United States worker delegate (Mr. Robert Watt, of the A. F. of L.) voted for; the employer delegate (Mr. Henry I. Harriman) voted against; and the two United States Government delegates (Secretary of Labor Frances Perkins and Senator Elbert D. Thomas) abstained from voting. (See Record of Proceedings, I. L. Conference, Twentieth Session, Philadelphia, 1944, p. 269).) And when the Philadelphia documents were transmitted to Congress by the President (as required by the ILO constitution and our membership in the ILO), he did not recommend their adoption; and they received no further attention by Congress in the committee to which they were referred.

10. *Page 1775, last two paragraphs.*—This account of ILO procedures should be a warning to any informed person as to how garbled and inaccurate is the understanding—or, at least, description—of ILO activities by the author of the article.

The Governing Body has no authority to adopt "recommendations." After considering any suggestions made by member governments or representative organizations of employers and workers, the Governing Body decides what items shall be placed on the agenda for a meeting of the Conference, the full delegate body of the Organization. Any member government may object to the inclusion of any item on the agenda, in which case the decision as to whether it will be included or excluded is made by a two-thirds vote of the Conference itself. The Conference may also decide, by a two-thirds vote, to include any subject on the agenda for the subsequent meeting of the Conference.

Subjects included on the agenda of a forthcoming Conference are discussed in advance—on that point the author of the article is right. The author is also correct in saying that it requires a two-thirds majority vote for the adoption of a proposal (although the phrasing of the statement implies some doubt as to the weight or validity of a two-thirds majority vote). Proposals adopted by a Conference may be in the form of either conventions or recommendations. A convention is not, as the author says, simply a recommendation which has received an affirmative vote. Rather, a convention is a proposed treaty, whereas a recommendation is what its name implies.

Draft conventions, adopted by a two-thirds vote of the conference, must be brought to the attention of the appropriate legislative body in each member nation. But the decision whether or not to ratify the convention is made by the national legislature—in this country, by the United States Senate, which, under our Constitution, is entrusted with the treaty-ratifying power. There is no obligation to ratify and, as was pointed out earlier, the United States has ratified only five conventions since we became a member of the Organization. Recommendations are not even acted upon formally by the Congress. Of course, if the Congress should think that some of the standards embodied in an ILO recommendation are sound and desirable for this country, it may enact legislation putting such standards in effect. In many matters (e. g., protective legislation for women, hours of labor, safety conditions, etc.) standards in this country have been higher than those which have been adopted by an ILO Conference as a feasible minimum for all countries.

The ILO procedure is essentially one of education and gradual acceptance of minimum standards, which have no force in any country until measures carrying them out are adopted by the country itself. Note how this process is misrepresented in the author's statement: "Following is the procedure used by the ILO to effect legislation among its member states."

11. *Page 1776, fourth full paragraph.*—Note again the charge that the W-M-D bill is a rewritten form of the ILO "draft conventions." The fact, as noted before, is that the W-M-D bill was introduced in Congress before the ILO worked out the "draft conventions" to which the author refers. Incidentally, the ILO "114 proposals" of Philadelphia, 1944, were not conventions; they were merely "recommendations."

12. *Page 1776, fifth and ninth full paragraphs.*—Here is a typical misrepresentation of a specific episode.

(*a*) The meetings in Montreal in July 1943 were not of "an ILO subcommittee on medical care (which) has been active for a number of years." It was an informal meeting of consultants invited by the International Labor Office. If there was such a subcommittee, it has certainly been inactive for years.

(*b*) The origin of the author's account of something alleged to have happened at the Montreal meetings was unknown to me, until I consulted a copy of the provisional minutes. It is alleged that Falk was responsible for change of one phrase to another in the Office proposals for medical care services. A review of the minutes, and comparison with the agenda document, shows that the author of the article puts a sinister meaning on an editorial change—of a wholly obvious kind—to clarify the text.

The fact is that the original document prepared for the meeting by the ILO staff said: "Medical care services * * * are regulated by law"; which is certainly true. And it said later concerning "Public General Service" that such a service implies "kinds of care defined by law," which was their definition of what they were talking about. The proposals as developed and adopted at the Philadelphia Conference [recommendation (N. 69) concerning medical care] say:

"*Essential features of a medical care service*"

"(1) (purposes).

"(2) The nature and the extent of the care provided by the service should be defined by law."

What there is sinister in all this, only the author of this article can explain. And only that author can find in all this "careful concealment of purpose," "ILO strategists," and "the virtues of national socialism." [The text of the article started out as though it was going to prove "international communism," but here the target has shifted to "national socialism."]

13. *Page 1776, tenth full paragraph, column 2.*—Here the text refers again to the "114 detailed proposals" adopted in Philadelphia in 1944. And the author says "a majority of the 114 proposals are embodied directly or by implication in the W-M-D bill of 1945 (S. 1050)."

(*a*) As already pointed out, the W-M-D bill of 1945 (S. 1050) was a slightly modified version of the W-M-D bill of 1943 (S. 1161). Thus, S. 1050 was not derived from the Philadelphia adoptions of 1944, but from a 1943 bill by the same Members of Congress. If the 1944 Philadelphia proposals resemble the W-M-D bills, it must mean that the ILO borrowed from the W-M-D bills, not the other way around.

As a matter of record, the document entitled "Plan of Discussion" prepared by the ILO staff for the Montreal (July 1943) meetings specifically referred to the Beveridge report, the Mexican Social Insurance Act, December 1942, the Marsh and Heagerty reports in Canada, the new Brazilian and Cuban plans; and then it went on to say: "Most recent of all is the Wagner-Murray-Dingell bill, introduced into the United States Congress in June 1943 * * *."

(*b*) The Philadelphia proposals outline the features deemed desirable in either a public medical service or a social insurance system. Since the W-M-D bills (1943 and 1945) propose social insurance (and not a general public medical service) it must be obvious that there will be items of similarity between the bill and the ILO proposals (on social insurance) and equally, there will be items of disagreement. The author of the article notes only the similarities, not the disagreements.

(*c*) The author says (in the text) that at the Philadelphia Conference "delegates adopted a medical care recommendation embracing 114 detailed proposals to guide member states in developing their health services." A footnote after the word "delegates" says: "The United States delegation was composed of the following persons * * *." Is it not fair to assume this was intended to give the reader the impression that the United States delegation voted for these proposals and helped adopt them? Well, the fact is that they didn't. As pointed out earlier, the United States Government delegates did not vote to adopt the 114 proposals or any of them.

14. *Page 1776, paragraph 11.*—Here follows a typical misrepresentation of the content of the ILO recommendation (No. 69) concerning medical care. Since the United States did not approve it, there is no need to examine the author's misrepresentations in detail. One point deserves comment, since the author of the article harps on it. "All medical services would be regulated by law." The author of the article makes that sound horrible and monstrous to physician readers. Yet every physician knows, when he is not under influence of that author's pen, that medical service is regulated by law. Does any physician doubt for a moment that it is necessary to have medical licensure laws, etc.? What he doesn't know is that the author of the article has translated the following—

"The nature and extent of the care provided by the (medical care) service should be defined by law" (Philadelphia, 1944).

Into

"All medical services would be regulated by law" (Medical Economics, 1945).

Imagine the author's shrieks if it were proposed that a medical care service (whether a public medical service, or a social insurance system—the two subjects being discussed in the Philadelphia recommendations) were not defined by law but were left to "bureaucrats" to decide.

15. *Page 1777, paragraphs 1–5.*—Then follows another typical performance. The author of the article says: "Drastic limitations on physicians' dispensing and prescribing and on the pharmaceutical industry are specified in regulations proposed by the ILO. For example:" Then follows a series of quotes that are not identified. But—as far as I have identified them—they don't happen to come from (as the author of the article says) "regulations proposed by the ILO"; they come from a volume written by technical experts who were studying and reporting on practices and experience under certain health insurance systems and distilling out of them what seemed to them to be the lessons that had been learned. The author's quotes "In several countries pocketbooks * * *" etc. I have found in the document entitled "I Consultation of Experts by the ILO, Conclusions of the Experts," pages 303–304 of the volume Economical Administration of Health Insurance Benefits (ILO, M, No. 15, 1938). A glance at the list of the experts, and at the context from which the quotes is extracted, will show how misleading is the use made of it here.

16. *Page 1777, paragraphs 6–7.*—Next is the author's allegation that "international administration" "of social security (including socialized medicine)" "is a leading ILO goal." Any informed person would know that this is nonsense. But this is only a preliminary to show the internationalism of the ILO. "Proposals for an International Health Organization" next get attention. According to the author of the article, under Senate Joint Rresolution 89, "Socialized medicine would be administered within the framework of the United Nations, with the

United States as one region of activity." The reader may not recognize this as the Senate resolution encouraging the recently developed World Health Organization (WHO) affiliated with the United Nations, and which has been hailed by leaders in all walks of life as one of the great accomplishments of the United Nations towards world peace and order. [Incidentally, note that Senate joint resolution "was introduced in our own Congress by Senators Pepper, Wagner, Murray, Capper, Ball, and Smith." This invites us to think of the last two (Senators Ball and Smith), who on May 3, 1946, joined with Senator Taft in introducing his National Health Act of 1946, as sponsors of legislation under which—according to the author's article in November 1945—"socialized medicine would be administered within the framework of the United Nations with the United States as one region of activity."]

17. *Page 1777, last 2 paragraphs.*—Next comes an attack on private organizations that have been striving for international collaboration for peace and world progress. And this is followed by an attack on the efforts to develop an international civil service of men and women who—when serving an international organization—must not be subject to national pressures and must be wholly loyal to the international organization. Is it conceivable, at this time, when our whole world is hoping and praying for the successful organization of the United Nations, for effective organization of atomic-bomb control, etc., that there will be any substantial agreement with the narrow and dangerous nationalism the author of this article preaches?

18. *Page 1778, paragraphs 7–9.*—The author's atack on the Social Security Board consists in showing that officers of the Board participate in the work of the ILO, and implying there is some evil plot in all this. The author might as well have added illustrations of the same kind that Mr. Byrnes, our Secretary of State at the time, was engaged in some similar plot since he was participating in the international discussion of peace treaties, of the United Nations, etc. And the same would be true for almost every person—whether a Government official, or a representative of business, labor, agriculture, etc.—who participates in any kind of international conferences, organizations, etc.

This is the stuff of which the attack on "socialized medicine" is made by the author of the Medical Economics article.

19. *Page 1778, last paragraph.*—Upon looking this up I find that Carter Goodrich was an "expert" consultant to the Social Security Board in its very earliest days. He was on a per diem basis; he did some work for the Board in 1936 and was paid for it; and did not work for the Board after September 1936.

20. *Page 1779, paragraph 3.*—I have inquired and have not found anyone here who knows of any ILO employees who, as alleged, were placed on the Social Security Board pay roll when the ILO transferred from Geneva to Montreal.

21. *General.*—This article in Medical Economics attempts to fabricate a case to prove that the ILO was and is an instrument for "internationalism" of an obnoxious type. It has already been mentioned that the ILO and the various national delegations to it are organized on a three-way basis—government, employer, and labor representatives. It is, therefore, not surprising that employer representatives who have actively participated in the work of the ILO should resent the misrepresentation of the ILO in this Medical Economics article. A letter which an employer representative on the United States delegation, 1944, Mr. Clarence G. McDavitt, wrote to Medical Economics has already been introduced into the record of these hearings.

22. *General.*—The article is a fake in its attempt to make it appear that national interest in health insurance is an "international" plot for "socialized medicine."

Any informed person knows that the health-insurance movement in this country is a wholly American development. Its roots go back to health insurance first enacted for seamen by the founding fathers in 1798. It has important origins in workmen's compensation legislation enacted nationally and in the States over the past 30 or 40 years.

The modern movement for health insurance in the United States began in 1927 with the formation of the Committee on the Costs of Medical Care (CCMC), under the chairmanship of Dr. Ray Lyman Wilbur who, at that time, was president of Leland Stanford University. He had formerly been professor of medicine and dean of the medical school, and was a past president of the American Medical Association. Later, after the committee became engaged in its 5-year study of medical economic problems, he became President Hoover's Secretary of the Interior. He kept on as chairman of the committee—as an unofficial job, since the committee never had any official status or connection with Government but remained a wholly private organization 1927–33.

The next major development, after the CCMC, was the study of health insurance by President Roosevelt's Cabinet Committee on Economic Security (1934–35), which made a report on this subject.

Next, the work of an Interdepartmental Committee, appointed by the President after enactment of the Social Security Act in 1935, and the development of a national-health program (1937–39). This program was extensively discussed at a national-health conference held in Washington, D. C., 1938, by representatives from all important parts of our democracy—including the medical profession. In the following year, Senator Wagner introduced the first bill to carry out that national-health program (S. 1620, 1939). The Wagner-George hospital bill (S. 3230, 1940), the Wagner permanent-disability insurance bill (S. 3924, 1940), the Wagner-Murray-Dingell bill of 1943 and 1945 were a succession of legislative proposals following the original 1939 bill, dealing with national health and national social security.

These are the high points in a factual account, as distinguished from the Red bogey published by Medical Economics.

THE CONSEQUENCES OF S. 1606—HISTORY OF BISMARCK'S POLITICAL HEALTH PLAN IS SEEN AS WARNING TO UNITED STATES

[Medical Economics, July 1946, page 109ff]

Marjorie Shearon, Ph. D., the author of the accompanying article, is one of the Nation's top authorities on social security. Her volume, "Economic Insecurity in Old Age," prepared for the Social Security Board, was used as a brief by Justice Robert H. Jackson when he defended the constitutionality of the Social Security Act before the Supreme Court. In reading the majority decision upholding the act, Justice Benjamin Cardozo quoted extensively from the volume. After engaging in public administration and research for many years, Mrs. Shearon joined the staff of the Social Security Board in 1936. She resigned in 1941, "having come to the conclusion that compulsory sickness insurance legislation was being prepared by the board not as a health measure but for the purpose of centralizing great power and funds in a single, nonhealth agency." Mrs. Shearon is presently research analyst for the Conference of the Minority, U. S. Senate. The accompanying material was prepared for the National Industrial Conference Board and is published by special arrangement with that board and the author.

The Wagner-Murray-Dingell bill of 1945 and the earlier version of 1943 find their prototype in the insurance laws of Bismarck. During the 1880's Bismarck, acting on the recommendations of his economic adviser, Adolph Wagner, professor of political science at the University of Berlin, laid down the general principles of social insurance. Laws of sickness insurance, accident insurance, and old age insurance were enacted despite bitter opposition. Bertrand Russell has said that Bismarck's aim was, "first to muzzle the official Social Democrats, and then, by a series of small bribes, to wean the proletariat from their adherence to revolutionary principles."

Bismarck translated into law the theories of the man who is credited with having done more than anyone else to give to state socialism its "scientific form and scientific foundation." Professor Wagner's social philosophy and total program for state control were outlined in an article published in 1887 in which he advocated public ownership of banking, insurance, communications, and utilities, and state "insurance against sickness, incapacity, and old age." He likewise proposed a new scheme of taxation that would not only serve the legitimate purpose of raising revenues but would at the same time constitute what he called "regulative interference."

This "interference" was to operate by regulating first the distribution of income and wealth and second the purchasing power and living habits of the "lower classes." The latter form of "interference" was to be accomplished "by administrative measures, and eventually by compulsion." Wagner stated: "This two-sided policy of taxation I call social. The second side here advanced * * * is based, as concerns the mass of the population, the lower laboring classes, on the assumption that in the truest interests of the nation a guardianship may and must be exercised over the national consumption or over the application of income to personal purposes."

His "social" insurance laws, thrown as a sop to the socialist Cerberus, were acclaimed as "the high-water mark of German state socialism." Designed to quiet the complaints of the socialists and at the same time to ease the burden on the local governments for care of the sick poor, they were political and economic devices rather than health measures. The law of sickness insurance was passed without the professional advice of health and medical experts and physicians, and administrative control was placed in lay hands. Bismarck, it is to be remembered, was hard-pressed for funds. He was seeking new sources of revenue. In the guise of what he called "practical Christianity," he induced the Reichstag to approve his new plan for taxing the workers, thereby making them shoulder the burden of most of their own poor relief. In return for their acceptance of the principle of "compulsion" and of control by a powerful bureaucracy, the "lower classes" were promised pitifully small and limited benefits.

German sickness insurance was financed by taxes on employers and employees, the latter (until as late as 1934) paying two-thirds of the cost. The Government provided the compulsion and interference; labor and management footed the bills. The doctors were squeezed between the upper and nether millstones of regulation and interference. Benefits were of two kinds: A cash sickness benefit equal to not less than one-half the daily wage, and free medical and hospital care during the illness. Minimum benefits were for 26 weeks with optional extension to 52 weeks if funds were available. Small maternity benefits and death benefits were also provided. Originally coverage was limited to low-paid workers in a few occupations; ultimately it was extended to all manual workers and all others with incomes not exceeding 3,600 reichsmarks annually, so that, with dependents, two-thirds of the population was covered. Under the law total "contributions," the euphemistic name given to the new taxes, could not exceed 7.5 percent of earnings and usually were limited to 6 percent. There was no state subsidy.

The Bismarck plan of social insurance has been adopted in over thirty countries, generally as a political, fiscal, and regulatory device. The schemes for compulsory sickness insurance have in the main followed the original pattern. While details vary from country to country, the distinctive characteristics of compulsion and "regulative interference" persist. Indeed, they are integral parts of the scheme and are, as many persons believe, the inherent cause of its weakness. Some countries have broader coverage, others more restricted. Great Britain insured only 40 percent of the population, and excluded dependents of workers. Russia, on the other hand, covered the entire population and carried the compulsory scheme to its logical conclusion by making all physicians the salaried servants of the state. New Zealand attempted complete coverage and a mixed system of payment for physicians. Thus, the framework and essential structure of the compulsory insurance features of the W-M-D bills are neither new nor original. They are a composite of Old World statutes written in such a manner that they may be incorporated into a comprehensive system of federally operated and controlled social-insurance.

In considering the sickness insurance bills now pending before Congress it would seem to be advisable to investigate the efficacy of the Bismarck plan. How well has it worked in the 60 years of its operation? Has it been administratively satisfactory, politically desirable, and medically sound?

Some of the answers to these questions are to be found in an appraisal of the German system made by Isidore S. Falk, who is generally credited with being the leader of the movement to establish Federal compulsory sickness insurance in the United States. After studying the German and other European schemes he stated in 1936:

"Observers are in general agreement that the German sickness-insurance laws and the central administration are very complex. For this there is a simple historical explanation and, perhaps we may say, justification. When first conceived, Bismarck contemplated a system which would absorb the existing insurance societies and provide for the formation of new ones. The state did not intend to contribute to the insurance benefits; the scheme was to be a mutual undertaking between employers and employees which the state was to supervise and regulate. In consequence, the benefits would be only those which the contributions from these two classes could finance.

"The state wished to make benefits appear as attractive as possible; but it dared not promise more than the contributors could and would support. The laws were therefore framed on the principle of specifying the minimum benefits which must be furnished and the maximum contributions which may be required. The system had to be framed to cover widely differing conditions among urban and rural communities and to meet the needs of all industrial classes, from the most substantial down to the dependent poor. Flexibility was therefore essential, and *flexibility meant various, diverse, and complex legal provisions.*" [Italics mine.]

The author then goes on to point out that the insurance societies responsible for administration of sickness-insurance funds had devoted too little money to public-health activities, spending in some years as little as 5 or 6 cents a person for the improvement of health. It is further admitted that German insurance practitioners were underpaid and suffered from lay controls.

In the light of these facts one may wonder why the Federal official who saw all the defects of compulsory sickness insurance should have written into the successive Wagner-Murray-Dingell bills the very provisions which he admitted were provocative of discord and reasonably certain to lead to autocratic rule, red tape, and limitations on freedom. The mixed system of remuneration of physicians which he has proposed has bankrupted one sickness-insurance scheme and might be expected to do the same thing in this country.

It is being loudly proclaimed at this time that Federal sickness-insurance legislation should be enacted forthwith in order to induce physicians to leave the cities and settle in rural areas. But the scheme did not have that effect in Germany, where after 60 years' operation it was observed that "the physicians of Germany are located in excessive proportions in the large cities and in inadequate proportions in rural areas." It has been stated repeatedly that the incomes of the majority of physicians would be improved under the provisions of the latest W-M-D bill. But insurance practice did not have that effect on the income of German physicians. In 1936, Mr. Falk stated:

"The inadequacy of professional income is even more discouraging in Germany than in the United States because it bears with unusual weight upon the insurance practitioners; whereas the less-than-average incomes of most physicians in the United States are 'compensated' by the greater-than-average incomes of the others; in Germany the less-than-average incomes occur mainly among insurance practitioners whose clientele is among the poor, and the greater-than-average incomes occur chiefly among noninsurance practitioners who serve private patients in the higher income classes."

It is significant to note that following the National Socialist revolution in 1933 Hitler reorganized Germany's social-insurance system. At that time, the Government's medical program was looked upon by many as one of the greatest props of the totalitarian state. The "leader" idea was introduced into the insurance system and Hitler issued a series of decrees in 1933, 1934, and 1935. "The new law, the decrees, and the regulations have profoundly changed the arrangements under which medical services are furnished. Where hitherto the contract of service had been left to each fund to be negotiated with each doctor, it is now a central contract governed by law and regulation," wrote Mr. Falk.

The two leading professional organizations of German doctors were dissolved. Hitler gave exclusive legal status to the sickness-insurance doctors of Germany. This group was given authority by decree to furnish medical services to insured and uninsured persons and to decide on remuneration. It was given responsibility for the punishment of its members. In this connection, I would point out, as others have before me, that a comprehensice government sickness-insurance scheme with its nation-wide bureaucratic machinery lends itself to administrative abuses with peculiar ease when the central power passes to a sadistic leader of the Hitler type. Punishments are devised for physicians and patients; the rights of the individual are abrogated. This was done in Germany. It could be done here.

It is obviously impossible in this short statement to enter into an exhaustive discussion of the attributes of a compulsory sickness-insurance program. I should, however, like to say a few words about the operation of the principle of regulative interference. The claim is frequently made that compulsory sickness insurance does not change the practice of medicine. Patients, it is said, will be free to enter or to remain out of the system; physicians will enjoy similar freedom. Patients may freely choose their physicians from among those who have consented to become insurance practitioners and have signed a contract with the Federal Government to abide by the rules and regulations to be issued in Washington.

Is this freedom? Patients would have about as much freedom as a prisoner in a Federal penitentiary would have if given the choice of working on the rock pile or in the prison laundry. Physicians on their part would be expected to make a blind date with the official in Washington who would one day promulgate the insurance rules and regulations which would have the force of law.

And what about patients? Under the latest W-M-D bill, insured persons would be given the following degree of freedom: Once the law went into effect every insured person would be informed as to the doctors in his particular insurance district who had agreed to become insurance practitioners. If the panel or capitation system such as is used in Great Britain were adopted, there would be a limitation of, say, 1,000 or 1,500 patients per physician. Insured persons would be given a certain period of time to sign upon some doctor's panel. If they failed to act they would, after due notice, be assigned to some doctor by the Surgeon General of the Public Health Service or his local representative. Clearly there would be a rush to get on the panels of those doctors who were considered to be the best in the community—assuming that they would consent to enter the system. Persons who delayed or were recalcitrant would have to take the less satisfactory doctors or would compulsorily be assigned to doctors whose lists had not filled rapidy.

Persons moving into the neighborhood would have to be content with the left-overs. If it so happened in a small community that none of the doctors were particularly good, insured persons would still be compelled to sign up with them and could not make arrangements with better qualified doctors in adjoining communities unless they did so at their own expense in addition to paying their increased social-security taxes and income taxes. Under the panel system of insurance practice the insured person becomes a pawn to be placed on panels at so much per head per year for the purpose of guaranteeing to physicians minimum incomes which tend in time to become maximum incomes.

Under the W-M-D bill, specialists would be available, as a rule, only on the advice of the insurance doctor. Obviously there might be occasions when a patient would demand a specialist and the insurance practitioner in the interests of economy would refuse his consent. In such a case the patient would be compelled to refer his appeal for the services of specialists and consultants to the local medical administrative officer appointed by the Surgeon General. Anyone who has endeavored to obtain quick action on an appeal to a Government agency in connection, let us say, with an OPA regulation will appreciate that a critically ill patient would probably be dead before he could obtain a ruling on his right to specialist and consultant services.

This is what is meant by regimentation and regulation of patients—this, multiplied a thousand-fold. It is claimed that under the W-M-D bills insured persons would receive "the best modern medical care." The bill does not so promise. Instead, it specifies cheap and limited services. It would, for instance, pay hospitals "not less than $3 and not more than $7 for each day of hospitalization, not in excess of 30 days." This implies ward service. Indeed, the language in the bill refers to payment for "essential hospital services, including the use of ward or other least expensive facilities compatible with the proper care of the patient." Always the emphasis is on economy, on the protection of the insurance funds rather than on the "best modern medical care" which is nowhere mentioned in the bill.

The claim is made that patients not only have freedom of choice of physicians but that they may change doctors if they are dissatisfied. Again, they have that brand of freedom that is permitted under Government dictatorship. If we may judge by the "freedom" accorded insured persons in other countries, it is perfectly clear that such limited freedom as will be enjoyed will obtain at the moment of entering the system. It does not mean freedom to pick the doctor you want at the time of sickness which may be months or years after the date of entry into the sickness scheme. In Great Britain, the patient seeking to change insurance doctors must obtain the written consent of the doctor who is being dropped and of the doctor whose services are sought. But the need for change generally arises as an emergency matter when minutes may mean the difference between life and death for the patient. Perhaps under the new dispensation death, before striking, will wait for an official O. K. from Washington.

We can presently be philosophical about Government red tape in connection with controls over industry, consumers goods, and prices. We look forward to the day when such controls will be removed. There is something grimly humorous about interminable forms in triplicate. One can even believe—albeit with difficulty—that one still has a court of last resort when one is told that if dissatisfied with the ruling of the administrator in a regional office, one may, within 90 days, appeal to the authorities in Washington by filing the appropriate official forms (seven copies, please). If one is still dissatisfied there is a modicum of comfort in knowing that one may finally appeal to the Supreme Court of the United States. This routine may have elements of humor when inanimate goods are concerned. There would be nothing humorous if a life were at stake. Nor can it be argued that analogies are farfetched.

The degree of "regulative interference" with patients and physicians under the British and German sickness insurance schemes is unbelievable. Consider the provisions of the German Insurance Code with respect to hospital treatment. Economy of administration is the dominant note. Thus, when it appears to an insurance practitioner that a patient should be hospitalized the code specifies that "the attending practitioner must prove the necessity of hospital treatment in writing." Furthermore, the code and contract regulations specify that "the consent of the sickness fund must be obtained before admission to hospital except in urgent cases. The patient's consent is not required (1) if the nature of the illness is such that treatment and nursing cannot be given at the home of the patient; or (2) if the disease is infectious; or (3) if the patient repeatedly disregards the doctors instructions or the rules for the conduct of patients." Is this regimentation?

The insurance system in Germany is policed by medical referees "in respect of the economy and the standards of medical treatment." Medical referee service centers are set up, there being one medical referee for every 25,000 insured persons. These medical referees, among their many duties, "are consulted, if required, before admission of patients to hospitals."

Doctors are under strict control with respect to the prescriptions they may write. "The standard cost of prescribing per case treated is fixed in the national agreement for the whole country." If on investigation by a medical referee it is decided that an insurance doctor has written prescriptions that are deemed too expensive or has prescribed costly new drugs without sufficient justification, the doctor may be penalized by having the excess amounts deducted from his government reimbursement. Such prohibitions ultimately lead to rigidity.

These are a few of the restrictions that hamper physicians under compulsory sickness insurance chemes. They are to be found in the rules and regulation in all countries having medical insurance benefits; such regulations are numbered by the thousand. This is what is meant by regimentation of doctors and patients. This is what lowers the quality of medical care and stifles initiative.

The International Labour Office has published an exhaustive volume entitled "Economical Administration of Health Insurance Benefits." The first part consists of 133 pages describing the principle of economy in administration of health benefits; the second part consisting of 173 pages is devoted to the principle of economy in national laws and regulations. There are rules for the conduct of patients, rules for doctors, rules for hospitals, rules for prescribing, etc. The basic law, complex as it is, is but a very small part of the regulatory machinery of sickness insurance. Thus, in Great Britain the laws of national health insurance, the rules and regulations, and the interpretation thereof are set forth in a volume nearly 1,300 pages long and every insurance practitioner has on his desk a volume of over 350 printed pages known as the doctor's bible, which informs him as to what he may or may not do.

It is of the utmost importance to realize that the three Wagner-Murray-Dingell bills were not drafted along American lines but are in direct conformity with the international provisions which have been laid down by the International Labour Office; these in turn largely reflect the German viewpoint with respect to the nationalization of medicine and the concentration of power in central governments.

With reference to the two W-M-D bills, I wish especially to direct attention to the devices employed for the purpose of conferring vast power on the Social Security Board. First, there is created a national social insurance trust fund which is to be held by a board of trustees consisting of the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board. To this fund would be transferred all the present assets of the Federal old-age and survivors' insurance trust fund. Into this fund there would pour all the new and greatly increased social-security taxes—4 percent of pay rolls from employers and 4 percent from employees, plus 5 percent of the income (up to $3,600) of self-employed persons, and such other tax receipts as might be paid in the form of premiums for insurance for the State employees and statutory beneficiaries, plus, finally the Government subsidy which might run as high as 50 percent of the cost of the program.

The Social Security Board, instead of the Bureau of Internal Revenue, would collect the taxes. The Board would unquestionably play a dominant role in the management of the fund. Furthermore, although all the health funds of the country would presently or ultimately flow into this national social-insurance trust fund and would constitute approximately one-fourth thereof, the W-M-D bill (S. 1050) does not include on the board of trustees any representative of the health and medical professions. Despite assurances that the health funds would be protected, the fact remains that they would be controlled by laymen, and that the Surgeon General of the Public Health Service would have to go hat in hand to the Chairman of the Social Security Board for approval of the contracts he would make with hospitals, doctors, and dentists. This bill would subordinate the health interests of the country to an agency—the Social Security Board—which has on its staff, so far as I know, not a single licensed practitioner of medicine.

The bills are so drafted with respect to compulsory sickness insurance that the main administrative authority over the lives of all the people in this country would be subtly vested in the Social Security Board. Note the language of S. 1606: The Surgeon General is authorized to draft the all-powerful rules and regulations for the compulsory sickness insurance scheme, but he may not perform this, his most important administrative function, until he has consulted the Social Security Board and obtained the approval of the Federal Security Administrator. He must consult with the Social Security Board when he makes studies and recommendations concerning the provision of personal health services. He cannot make a move without consulting a lay board unskilled in medical matters and without obtaining the approval of the Federal Security Administrator, who is not a physician.

These may seem like unimportant details until it is realized that they are the essence of control. The statutory provisions which have been deftly woven into the Wagner-Murray-Dingell bills relate particularly to (1) the control of the national social insurance trust fund, in which may some day be deposited upward of one-fourth the annual national income, and (2) the top policy-forming council, the so-called National Advisory Social Security Policy Council, which is appointed by the Social Security Board. This policy council is not limited in size and power as is the insignificant and wholly inadequate National Advisory Medical Policy Council which the Surgeon General is permitted to appoint. Although there is no statutory provision for inclusion among its members of any health or medical representatives, the Social Security Policy Council is authorized inter alia to make findings and recommendations on the "administration of medical, hospitalization, and related benefits." This extraordinary provision would permit determination of high policy in connection with the national health program by professionally unqualified, nonmedical advisers. I believe it to be an extremely dangerous provision.

The suggestion has frequently been made that amendments should be proposed to the sickness insurance title of the latest W-M-D bill and that the bill might thus be made acceptable. This is like asking a builder to remodel a Federal penitentiary into a California bungalow. One cannot have freedom within the framework of compulsory sickness insurance. It is political double talk to speak of freedom and compulsion as conditions which may be enjoyed simultaneously. Perhaps the people of America wish to seek health under a scheme of nationalized medicine. But I doubt if that is the case. To the extent that they are sold on the idea they have been sold by promises that cannot be fulfilled.

The pay-roll tax proposed by W-M-D bill sponsors would be totally insufficient to finance the type of modern medical care that has been promised. We would not have the facilities or the health personnel even within 10 years. It would take the full time of all the doctors in the country to spend as little as 2 hours a year on complete health examinations for everyone in the country. The gap between the promises in connection with W-M-D bills and the possible performance is indicative of a lack of candor on the part of Government experts who withhold from Congress and the public the facts which they have in their possession and which should be made public.

If the companion W-M-D bills were to be enacted, the only thing that would be sure to materialize would be the proceeds of the tax provisions. Whether or not the Government could deliver the health and medical services it promises, the national social insurance trust fund would bulge with new revenues. A bureaucracy with undreamed of power would be established. Every family would pay tribute to the Social Security Board for the support of the system of nationalized medicine, to say nothing of other parts of the national social insurance system for which there is considerable valid justification.

That such legislation would lead to the abolition of the private practice of medicine is freely admitted by the International Labor Office in a recent pamphlet in which this statement appears: "The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. The *next step to a single national medical service is a short one* * * *." [Italics mine.]

(Dr. Falk's notes on the foregoing article follow:)

[Marjorie Shearon, Ph. D., is stated as author in the box. Referred to as "one of the Nation's top authorities on Social Security."]

Note that this article is referred to as having been prepared for the National Industrial Conference Board.

1. It is not practical to comment in detail on this article—without undertaking a large job—because nearly everything in it is wrong factually or is "slanted" to such an extent that the facts are misrepresented. The general tenor of the article is to invite the reader to believe, or to persuade him, that social insurance in general, and health insurance in particular, is administratively a failure, expensive, nonproductive, etc.; that it "regiments" the people, deprives them of liberty, security, and their earnings, has been forced upon them and continued despite them, etc. All of which is nonsense.

2. The opening section about Bismarck and Professor Wagner is Shearon nonsense. She makes it appear that Bismarck threw social insurance as a "sop" to the Socialists, but history has known for a long time (before Shearon came on the scene to rewrite it) that Bismarck developed social insurance to help destroy the Socialists (whom he had already had outlawed legally) by providing social security to deprive the public of a desire for socialism as a means to security.

3. *Page 116ff:* Mrs. Shearon quotes from my comments on the German system and asks why I "should have written into the successive Wagner-Murray-Dingell bills the very provisions which (I) admitted [in Security Against Sickness] were provocative of discord * * * (etc.)." But an inspection of specifications in the German system and in the Wagner-Murray-Dingell bills will show, I believe, this is merely rhetoric on her part. E. g. compare re coverage, use of "contracting-out" and place of voluntary insurance agencies, Government participation in financing, provision for preventive services, provision for participation of professions, etc. (Incidentally, which system was "bankrupted" by "the mixed system of remuneration of physicians"?)

4. *Pages 116–118:* Mrs. Shearon quotes from page 130 and from page 133 of Security Against Sickness to show the bad state of physicians' incomes in Germany and too-low expenditures for preventive services. But note that she carefully skipped what I said at the bottom of page 131 (the explanation, which suggests the remedy incorporated in the W-M-D bills). [Also note that she ignores what I said re adequate financing, on pp. 281–283 of chapter XIII, and at various points in chapter XVI.] [Also note that she quotes the 5 and 6 cents per capita for health activities in 1924 and 1925 (p. 133), but doesn't cite the 11 cents per capita in the next sentence (a really substantial sum by comparison with public-health expenditures).]

5. *Page 120ff:* Here the usual Shearon misrepresentations and misinterpretations of the W-M-D provisions. Nearly every point she makes is based on an inadequate statement of the provisions or on a twisted interpretation.

Senator DONNELL. I have one other thing, Mr. Chairman.

Senator Murray will doubtless recall that Dr. Reginald M. Atwater, Executive Secretary, the American Public Health Association, was called to testify with respect to S. 1320.

Do you remember him, Senator?

Senator MURRAY. Yes, I do.

Senator DONNELL. A request was made of him on June 27 to give certain supplemental information, which was furnished by him under date of July 3, and I have the letter and the supplemental information. I offer it for the record at this time.

Senator MURRAY. If it is necessary for us to call for a cross-examination when the hearings reopen, we would like to reserve the right to do so.

Senator SMITH. Yes.

Senator DONNELL. I have no objection to the cross-examination of the witness. However, he was a witness called by the proponents of S. 1320.

Also, Mr. Chairman, my answer to Dr. Atwater of July 9, the concluding sentence of the first paragraph of which says:

> If there is any other portion of the above-mentioned constitution which you would like to have incorporated, kindly notify me what said other portion is * * *

He sent me a constitutional provision so that the committee could decide if it was of sufficient importance to justify printing in the record. I offer this correspondence so that the committee can take such action as it deems proper.

(Dr. Atwater's letter and material submitted are as follows:)

THE AMERICAN PUBLIC HEALTH ASSOCIATION,
New York 19, N. Y., July 3, 1947.

HON. FORREST C. DONNELL,
Senate Office Building, Washington, D. C.

DEAR SENATOR DONNELL: In accordance with your request of June 27 at the hearing of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, I give you the following supplemental information.

You will recall that you read into the record of the hearing an editorial beginning on page 434 of the Journal of the American Medical Association, October 14, 1944, relating to the declaration on Medical Care in a National Health Program which had recently been adopted by the American Public Health Association. You asked me to advise you of any errors of fact contained in this editorial.

In answer to your question, I enclose a copy of a letter to the editor of the Journal of the American Medical Association published in the November 18, 1944 issue commenting on this editorial from Edward S. Godfrey, Jr., M. D., then commissioner of health in the State of New York, who is chairman of the Committee on Constitution and Bylaws of the American Public Health Association. It will be noted that Dr. Godfrey was in the minority group on the governing council who, in the opinion of the editor of the Journal of the American Medical Association, were unfairly treated. Dr. Godfrey speaks with first hand knowledge of the facts.

It is respectfully suggested that this letter of Dr. Godfrey's in answer to the editorial in question be included in the record because it points out the fallacy of the editor's claim that the action was not of a democratic sort or truly representing the sentiment of the Association.

There is an error in fact in the editorial in question in that the total membership of the American Public Health Association is given as 7,493, whereas the correct figure at that date was 9,064, which figure is a total of the two figures given in the editorial for members and Fellows.

As pointed out by Dr. Godfrey's letter, it is not true that only fellows had a right to vote for governing councilors as stated in the editorial. The fact is that only fellows present at the annual meeting had a right to vote for the elective councilors, 10 of whom are elected each year for 3-year terms. Other members of the association present at the annual meeting, or present at the meetings of affiliated societies or branches, had the right to vote for the other members of the governing council, numbering approximately 70. The council therefore directly represents the membership of the association.

The American Public Health Association has pride in the record of its democratic procedure and, as secretary of the governing council at the 1944 annual meeting, I can testify that the vote of the governing council members of 49 to 14, favoring adoption of out statement, was as truly a democratic expression of a majority opinion as a similar vote of the United States Senate might be. The fact that subsequently there has appeared no move to reverse the action speaks for itself.

In accordance with your request, I submit a copy of the constitution and bylaws of the American Public Health Association in effect in 1944 with the paragraphs related to the election of governing councilors marked.

Since you are interested in the make-up of the subcommittee on medical care, I take the liberty of enclosing a list of the members of that subcommittee, together with a list of the members of the committee on administrative practice to which it is subordinate as of that date, and a list of the members of the governing council. It will be understood that these persons serve in their private capacity but their public position will be recognized as of the very highest.

You will recall that you inserted in the record the paper by Dr. W. G. Smillie entitled "An Appraisal of a National Health Program for Medical Care," published in the June 1945 issue of the American Journal of Public Health, calling attention to the fact that such a critical point of view appeared in the official publication of the American Public Health Association.

As chairman of the editorial board and managing editor of the American Journal of Public Health, let me say that the board encouraged the publication of this minority point of view. The association as a matter of principle welcomes such independent thought and takes real pride in this tradition of free speech. We wish that other professional journals had as liberal a policy in this regard.

In view of the fact that the record of the hearing of June 27 contains considerable material, included at your request, on which I was not prepared to comment in detail at the time, it is respectfully requested that this letter and such of the supporting documents as seem proper should be included in the transcript of the hearing.

Very sincerely yours,

Reginald M. Atwater, M. D.,
Executive Secretary.

The American Public Health Association

COMMITTEE ON ADMINISTRATIVE PRACTICE AS OF OCTOBER 1944

Wilton L. Halverson, M. D., chairman, director, State department of public health, San Francisco, Calif.
Haven Emerson, M. D., vice chairman, professor emeritus in public health practice, Columbia University.
Reginald M. Atwater, M. D., secretary, the American Public Health Association.
Gregoire F. Amyot, Provincial health officer, British Columbia.
Dwight M. Bissell, M. D., health officer, San Jose, Calif.
George B. Darling, Dr. P. H., staff of National Research Council.
Lloyd M. Graves, M. D., health officer, Memphis, Tenn.
Millard C. Hanson, M. D., health officer, Richmond, Va.
Ira V. Hiscock, Sc. D., professor of public health, Yale University School of Medicine.
Kenneth F. Maxey, M. D., professor of epidemiology, Johns Hopkins University,
Joseph W. Mountin, M. D., United States Public Health Service.
John T. Phair, M. B., D. P. H., Deputy Minister of Health, Province of Ontario.
George H. Ramsey, M. D., visiting lecturer of public health, University of Michigan.
W. S. Rankin, M. D., medical director, Duke Foundation, Charlotte, N. C.
Clarence L. Scamman, M. D., director, division of public health, the Commonwealth Fund.
Marion W. Sheahan, R. N., director of public health nursing, New York State Department of Health.
H. A. Whittaker, sanitary engineer, Minnesota State Department of Health.
Consultants:
    Henry F. Vaughn, Dr. P. H., dean of University of Michigan School of Public Health.
    C.-E. A. Winslow, Dr. P. H., professor of public health, Yale University School of Medicine.

SUBCOMMITTEE ON MEDICAL CARE AS OF OCTOBER 1944

Joseph W. Mountin, M. D., chairman, Unied States Public Health Service.
Earle G. Brown, M. D., commissioner of health, Nassau County, N. Y.
David D. Carr, M. D., health officer, Topeka-Shawnee, Kans.
Edwin F. Daily, M. D., United States Children's Bureau.
Graham L. Davis, W. K. Kellogg Foundation.
Isidore S. Falk, Ph. D., Social Security Board.
Katherine Faville, R. N., nursing department, Wayne University, Detroit, Mich.
J. Ray Hege, M. D., health officer, Forsyth County, N. C.
Hugh R. Leavell, M. D., division of medical sciences, Rockefeller Foundation.
Emory Morris, D. D. S., president, W. K. Kellogg Foundation.
George St. John Perrott, United States Public Health Service.
Edward S. Rogers, M. D., assistant commissioner, New York State Department of Health.
Nathan Sinai, Dr. P. H., professor of public health, University of Michigan.

THE AMERICAN PUBLIC HEALTH ASSOCIATION

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Vice president, Jean Gregoire, M. D., Quebec, Canada.
Vice president Pearl L. Kendrick, Sc. D., Grand Rapids, Mich.
Vice president G. H. de Paula Souza, M. D., Sao Paulo, Brazil.
Treasurer, Louis I. Dublin, Ph. D., New York, N. Y.
Chairman of executive board, Abel Wolman, Dr. Eng., Baltimore, Md.
Executive secretary, Reginald M. Atwater, M. D., New York, N. Y.

EXECUTIVE BOARD

Chairman, Abel Wolman, Dr. Eng., Baltimore, Md. (1945)
J. A. Doull, M. D., Cleveland Ohio (1945)
Louis I. Dublin, Ph. D., New York, N. Y., treasurer.
Hugh R. Leavell, M. D., Louisville, Ky., (1946).
E. G. McGavran, M. D., Clayton, Mo. (1946).
John J. Sippy, M. D., Stockton, Calif., president-elect.
Felix J. Underwood, M. D., Jackson, Miss., president.
Charles F. Wilinsky, M. D., Boston, Mass. (1944).
C. C. Young, D. P. H., Lansing, Mich. (1944).

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Terms expiring 1944

J. A. Doull, M. D., Cleveland, Ohio.
Martha M. Eliot, M. D., Washington, D. C.
Haven Emerson, M. D., New York, N. Y.
J. C. Geiger, M. D., San Francisco, Calif.
Kenneth F. Maxey, M. D., Baltimore, Md.
Stanley H. Osborn, M. D., Hartford, Conn.
I. C. Riggin, M. D., Richmond, Va.
George C. Ruhland, M. D., Washington, D. C.
William P. Shepard, M. D., San Francisco, Calif.
C.-E. A. Winslow, Dr. P. H., New Haven, Conn.

Terms expiring 1945

Margaret G. Arnstein, R. N., New York, N. Y.
E. L. Bishop, M. D., Chattanooga, Tenn.
Walter H. Brown, M. D., San Francisco, Calif.
V. M. Ehlers, C. E., Austin, Tex.
Selskar M. Gunn, New York, N. Y.
James P. Leake, M. D., Washington, D. C.
Arthur P. Miller, C. E., New York, N. Y.
Alton S. Pope, M. D., Boston, Mass.
W. S. Rankin, M. D., Charlotte, N. C.
Huntington Williams, M. D., Baltimore, Md.

Terms expiring 1946

M. E. Barnes, M. D., Iowa City, Iowa.
W. W. Bauer, M. D., Chicago, Ill.
George B. Darling, Dr. P. H., Washington, D. C.
R. E. Dyer, M. D., Bethesda, Md.
Edward S. Godfrey, Jr., M. D., Albany, N. Y.
Jean Gregoire, M. D., Quebec, Canada.
W. S. Leathers, M. D., Nashville, Tenn.
Hugh R. Leavell, M. D., Louisville, Ky.
Joseph W. Mountin, M. D., Washington, D. C.
John J. Sippy, M. D., Stockton, Calif.

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Secretary, George M. Wheatley, M. D., New York.

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Chairman, Kenneth A. Easlick, D. D. S., Ann Arbor, Mich.
Vice Chairman, J. M. Wisan, D. D. S., Trenton, N. J.
Secretary, W. J. Pelton, D. D. S., Bethesda, Md.

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Lawrence J. Peterson, Idaho
H. J. Shaughnessy, Ph. D., Illinois
Walter L. Bierring, M. D., Iowa
Raymond S. Patterson, Ph. D., Massachusetts
Emilie G. Sargent, R. N., Michigan
W. Scott Johnson, Missouri
Elroy F. McIntyre, M. D., New Mexico
Sol Pincus, C. E., New York City
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John D. Fuller, M. D., Northern California
Leo F. Ey, Ohio Federation of Public Health Officials
William W. McFarland, M. D., Pennsylvania
James A. Hayne, M. D., South Carolina
John F. Kessel, Ph. D., Southern California
James B. Black, M. D., Tennessee
William A. King, M. D., Texas
E. H. Bramhall, Utah
Laurene C. Fisher, West Virginia
——— ———, western branch
——— ———, southern branch
Domingo F. Ramos, M. D., Cuban Public Health Society
A. Fernós-Isern, M. D., Puerto Rico Public Health Association

[Copy of letter from Edward S. Godfrey, Jr., M. D., commissioner of health, Albany, N. Y., to the editor, Journal of the American Medical Association, November 18, 1944, vol. 126, No. 12, p. 789]

I have noted with regret the leading editorial in your issue of October 14 entitled "American Public Health Association Health Insurance Declaration." As one of those who voted for the proposed amendment and against the final adoption of the report, I wish to correct certain prejudicial impressions which I believe will be given to a body of your readers relative to the representative character of the governing council.

I am willing to accept the figures given in the editorial as to the number of members and fellows, respectively, in the American Public Health Association. I would call attention, however, to the fact that the only members of the governing council whose election is restricted to a vote of the fellows are the 30 out of something over 100 mentioned in your editorial. The 41 members of the council representing the sections are elected by the membership and fellowship of each section.

Likewise, representatives of the affiliated societies and branches are elected by their fellowship and membership in accordance with their respective constitutions and bylaws.

The council is, therefore, a representative body, as is the house of delegates of the American Medical Association. Membership in the council and the right to hold office in the association are restricted to fellows, as they are in the American Medical Association.

The adoption of the subcommittee's report by a large majority of the quorum present is therefore quite as proper and as much in order as any action taken by the house of delegates of the American Medical Association and, in my opinion, equally representative of the opinion of the entire membership.

I voted for the amendment proposed by Dr. Bierring because I feel that the cooperation of the medical and dental professions is essential to the successful operation of any plan designed to extend medical care and to improve its quality.

On the other hand, I think that the attitude of the American Medical Association has been such that a majority of the council felt that a conference on the subject would prove futile and would merely delay an expression of opinion from the American Public Health Association on a subject on which their minds were made up. The tone of your editorial would tend to confirm that opinion.

My vote against the resolution to adopt was based on my not having taken time, personally, to examine the report and study its content.

Constitution and Bylaws, American Public Health Association, as Adopted at the Fifty-eighth Annual Meeting, and Amended at the Seventy-second Annual Meeting, 1943

CONSTITUTION

Article I, Name

The name of this association, incorporated under the laws of Massachusetts, is the American Public Health Association.

Article II, Object

The object of this association is to protect and promote public and personal health.

Article III, Governing council

A. Composition: There shall be a governing council consisting of—

1. The officers of the association and the elective members of the executive board.

2. Thirty members of the council, to be elected by and from the fellowship of the association, for 3-year terms, one-third retiring each year. These members of the council shall be nominated and elected as provided for in the bylaws.

If one of these members is elected a section chairman, vice chairman, or secretary, or appointed the representative of an affiliated society, or a regional branch, a new councilor to fill such vacancy shall be elected by the governing council.

3. The chairman, vice chairman, and secretary of each section.

4. Representatives to be appointed by affiliated societies as provided for in the bylaws. Such representatives shall be fellows of the American Public Health Association.

5. The elective members of the council of the health officers section.

6. A representative to be designated by each regional branch. Such representative shall be a fellow of the American Public Health Association.

B. Terms: Terms of councilors shall begin at the end of the annual meeting when elected, and shall terminate at the end of the annual meeting at expiration of term; provided that councilors shall have the right to attend meetings of the council in an advisory capacity as soon as elected.

C. Reelection: After two consecutive terms, an elective councilor shall be ineligible for reelection to the council during one association year.

D. The officers of the association shall be the officers of the council.

E. Functions: The functions of the council shall be:

1. To establish policies for the association and for the guidance of the executive board and the officers.

2. To establish sections of the association; to combine or discontinue them when necessary; to maintain coordination among them; and to formulate general rules governing the policies of the sections.

3. To consider all resolutions proposed for approval in the name of the association, and to receive and act upon a report from a committee on resolutions appointed by the president at each annual meeting.

4. To elect and establish qualifications for fellows, honorary fellows, life members, affiliated societies and regional branches and to recognize associated organizations as provided in the bylaws.

5. To elect the executive board and the officers of the association with the exception of the chairman of the executive board and the executive secretary.

6. To approve all standards promulgated in the name of the association.

7. To receive from the executive board at its first session, at the time and place of the annual meeting of the association, a definitely formulated statement of a program of the major activities proposed for the ensuing year. To require a report from the chairman of the executive board in which the work, the accomplishments, and the financial status of the association during the year preceding such annual meeting shall be reviewed.

8. To publish after each of its meetings an abstract of the minutes of such meetings.

F. A quorum of the council shall consist of 10 councilors.

G. Meetings of the council shall be called by the executive secretary at the request of the president, or at the request in writing of any 12 councilors. In the latter case, the call to meeting, issued at least 20 days in advance, shall state the purpose of the meeting.

Article IV, Officers

The officers of this association shall be a president, a president-elect, three vice presidents, an executive secretary, a treasurer, and the chairman of the executive board. The officers, with the exception of the chairman of the executive board and the executive secretary, shall be elected by written ballot of the governing council as provided in this article and in the bylaws. The president-elect shall serve as such from the close of the annual meeting at which he was elected to the close of the next annual meeting, when he shall automatically become president. As president he shall serve to the close of the next succeeding annual meeting. However, in case of the inability of the president to complete his term for any reason, the president-elect shall at once succeed to the duties of President, filling the unexpired term of his predecessor and his own term consecutively. Other officers shall serve from the close of the annual meeting when elected, until the close of the next annual meeting, and all officers shall serve in any case until their successors are elected and qualified. A majority vote of the councilors voting shall be required to elect, and if no candidate receives a majority vote on the first ballot, the candidate receiving the smallest number of votes shall be dropped after each ballot in succession until a majority vote is obtained. The chairman of the executive board and the executive secretary shall be elected by the executive board, which board shall define the duties and authority of these officers, respectively.

Article V, Amendments

This constitution may be amended by a two-thirds vote of the fellows of the association present and voting at an annual meeting, provided that the specific amendment to be acted upon is published in the official publication of the association not less than 30 days prior to the meeting, and provided further that the amendment has received the approval of the governing council.

BYLAWS

Article I, Membership and dues

A. There shall be eight classes of constituents who may be elected from any country. The respective appellations, qualifications for election, and dues shall be as follows:

1. Fellows: Professional health workers who have been members of the association for at least 2 years, and who are of established professional standing (whether employed by public or private organizations or in independent private practice), shall be eligible for election as fellows, provided that the applicant shall have reached his thirtieth birthday at the time application for fellowship is made.

The following persons shall be considered to have an established standing in the profession of public health for this purpose:

(*a*) A person who has rendered acceptable service for two or more years in a responsible public-health position and who has been awarded in course a degree of doctor of public health, doctor of science in public health, doctor of philosophy in public health, doctor of medicine with at least 1 year of graduate study in public health in a university, or other equivalent degrees, according to standards approved by the executive board of the American Public Health Association, after approval by the appropriate section council, or in the case of applicants for unaffiliated fellowship, by the executive board.

(*b*) A person who has been awarded in course an academic or professional degree involving training in public health and who has been regularly engaged in health work for at least 5 years, having rendered meritorious service as a health officer or in responsible charge of work in either a public or private health agency, after approval by the appropriate section council, or, in the case of applicants for unaffiliated fellowship, by the executive board.

(*c*) A person who has done notable original work in public health or preventive medicine of a character to give him a recognized standing, and who is unanimously endorsed for fellowship by the committee on eligibility after approval by unanimous vote of the appropriate section council, or, in the case of applicants for unaffiliated fellowship, by the executive board.

(*d*) A person regularly engaged in health work for at least 5 years, who has given evidence of special proficiency, who has attained a recognized standing, and who is endorsed for fellowship by not less than a two-thirds vote of the committee on eligibility after approval by unanimous vote of the appropriate section council, or, in the case of applicants for unaffiliated fellowship, by the executive board.

(*e*) A teacher of public health or one of its constitutent sciences who has attained distinction as an expounder of the principles of public health or its constituent sciences, and who is endorsed for fellowship by not less than a two-thirds vote of the committee on eligibility, after approval by unanimous vote of the appropriate section council, or, in the case of applicants for unaffiliated fellowship, by the executive board. Such a teacher shall have had at least 5 years' experience as a teacher of public-health subjects. Any years of experience as defined in paragraphs (*b*) and (*d*) that the applicant may have had shall be considered the equivalent of the same number of years' experience as a "teacher."

(*f*) A person not covered by the above, who has made substantial contributions to public-health work in his chosen branch, who has attained a recognized professional standing, and who is endorsed for fellowship by not less than a two-thirds vote of the committee on eligibility after approval by unanimous vote of the appropriate section council, or, in the case of applicants for unaffiliated fellowship, by the executive board.

The application for fellowship shall be made on an approved form and shall be sponsored by two fellows of the association who shall be fellows of the section with which affiliation is desired, provided, however, that when affiliation with a section is not desired, the sponsors may be any two fellows in good standing in the association. Fellows without section affiliation shall be known as unaffiliated fellows.

When the application has been duly sponsored and otherwise completed, it shall be transmitted to the administrative office of the association, which shall make note thereon of such knowledge as it may have concerning the standing of the applicant in the association. The application shall be forwarded by the administrative office to the secretary of the section in which affiliation is desired, for the approval of the section council, and, when acted upon by the section council, it shall be returned to the administrative office by the secretary of the section, after he has made endorsement on the application of the action of the section council. When the application is for unaffiliated fellowship, the executive board of the association shall act in place of the section council. When the application has been approved by the section council or the executive board, as above provided, it shall be voted upon by the governing council, provided the name of the applicant shall have been officially published at least 15 days in advance, and provided further that the application shall have been approved by the committee on eligibility.

A fellow may belong to and vote in only one section, but such affiliation may be transferred to another section if approved by vote of a majority of the council of the latter section. Unaffiliated fellows may become affiliated with a section if approved by vote of a majority of the council of the section with which affiliation is desired.

The right to hold office or to serve as chairman of a committee in the association shall be limited to the fellows of the association, whether section fellows or unaffiliated fellows. The right to hold office or to serve as chairman of a committee in a section shall, however, be limited to the respective fellows in such section. This provision shall not prevent the election of a vice president of the association who may not be a fellow.

The dues of fellows shall be $10 per year.

2. Honorary fellows: Honorary fellows may be elected by the governing council for distinguished service in public health. Honorary fellowship shall not include voting power or payment of dues. However, those honorary fellows who have previously been fellows of the association shall retain all the privileges of fellowship.

3. Members: Persons professionally engaged or interested in public health work shall be eligible for election as members when sponsored by two members or fellows of the association. They may serve on committees, except as chairmen. Dues $5 per year. A member may belong to only one section, but such affiliation may be transferred to another section if approved by vote of a majority of the council of the section to which change is desired. Unaffiliated members may become affiliated with a section if approved by vote of a majority of the council of the section with which affiliation is desired.

4. Sustaining members: Individuals or corporations interested in public health may be elected to sustaining membership. Dues $50 or more per year.

5. Affiliated societies: A State or Provincial public health association or similar regional society including more or less than a State, primarily composed of professional public health workers and organized for the same general objects as the American Public Health Association, may be elected as an affiliated society, provided that not less than 20 of its active members and at least one-half of its active members are members or fellows of the American Public Health Association. Not more than one such society shall be admitted from the same area.

A society applying for affiliation shall submit a copy of its constitution and bylaws, its last annual budget, a roster of its members and such other evidences of its qualifications as may be required. It shall submit annually and at other times such reports on its financial standing, membership and other matters as may be required by the executive board of the American Public Health Association.

The committee on eligibility shall consider all applications for affiliation and report its recommendations to the governing council.

The annual dues of affiliated societies shall be 1 percent of their gross annual income, the minimum dues per society being $10 per year.

For every fellow or member paying annual dues to the American Public Health Association, the American Public Health Association shall remit to the affiliated society of which such person is a member the sum of $1 per annum.

6. Associated organizations: The governing council at its discretion may recognize as associated organizations other autonomous agencies constituting professional societies.

7. Life members: Upon the recommendation of the committee on eligibility any individual member of the association may be elected a member for life. Election to this grade shall not affect the privileges held by such individual in his previous grade of membership. The dues for life members shall be $100, payable within 1 year after election, and this payment by such member shall exempt him from any further dues.

8. Regional branches: The governing council may at its discretion establish regional branches of the association.

B. Election: The election of fellows (see A1 above), honorary fellows, life members, affiliated societies, and regional branches, and the recognition of associated organizations shall be by the governing council.

The election of members and sustaining members shall be by the executive board.

Three-fourths of the votes cast shall be requisite for election.

Upon the recommendation of the committee on eligibility the governing council may discontinue the membership, fellowship, or affiliation of any constituent. Three-fourths of the votes cast shall be necessary for such action.

C. Dues: Dues are payable annually in advance. All constituents paying dues shall be entitled to receive the American Journal of Public Health and/or such other publications as may be designated by the executive board, which shall determine the proportion of dues to be devoted to this purpose.

Constituents of any class whose dues are unpaid for 6 months or more shall be considered not in good standing. Constituents not in good standing shall not be entitled to vote, hold office, or enjoy other priviliges or power of membership. Good standing may be resumed upon the payment of all arrears and dues in advance for 1 year, provided, however, the lapsed period is not greater than 1 year. The administrative office shall notify by registered mail all constituents who have been in arrears for a period of 11 months. The names of constituents in any class whose dues remain unpaid for 1 year or more shall be presented to the executive board which shall order the names of such constituents stricken from the membership roll, provided, however, such constituents have been duly notified as hereinbefore provided in this paragraph. Constituents whose names have been stricken from the rolls in this manner may be again admitted in the manner provided for the election of new constituents in the class for which they make application, provided such person or organization complies with the eligibility requirements at the time the new application is made.

D. Involuntary termination of membership: If, in the opinion of the executive board, any member or fellow of the association permits the use of his name, or otherwise allows himself to be quoted or used for illustration in the advertising of a commercial product, in such a manner as to reflect discredit upon the association, his fellowship or membership in the association shall thereupon be terminated.

Article II, governing council

The 30 members of the governing council designated in article III, section A, paragraph 2 of the constitution, shall be nominated and elected as follows: There shall be a nominating committee composed of one fellow elected by each section at the preceding annual meeting, and an additional fellow designated by the executive board, the latter serving as chairman. This committee shall present to the administrative office at least 2 months before the next annual meeting the names of at least 20 and not more than 30 fellows of the association selected with due regard to geographical and membership considerations as nominees for the governing council. The administrative office shall publish this list to the membership. Upon the petition of 25 fellows the nominating committee shall add the name of any fellow to this list provided such petition is received 15 days before the annual meeting. The time for closing the polls shall be determined each year by the executive board. The fellows receiving the highest number of votes on a written ballot cast by the fellows present and voting at the annual meeting shall be declared elected to fill existing vacancies. Should two or more candidates receive the same number of votes, the executive board shall, when necessary, determine by written ballot the order of precedence.

Article III, Executive Board

A. Composition: There shall be an executive board of nine members elected by the governing council, six of whom shall be at the time of their election past or present members of the governing council, and three of whom shall be the president, the president-elect, and the treasurer.

1. When a fellow accepts membership on the executive board, any position he may hold on any of the standing committees of the association will thereupon automatically become vacant.

2. If a vacancy on the executive board shall occur after the annual meeting because of the preference of an elected member to retain his standing committee membership, the president shall designate a nominating committee for this purpose from the membership of the governing council and this committee shall nominate not less than three candidates for the vacancy, from whom the candidate receiving the highest number of votes of the governing council is a mail ballot shall be declared elected to the exectutive board to fill the vacancy.

B. Terms: The terms of the president, the president-elect, and the treasurer as executive board members shall be 1 year each. The terms of the other members shall be 3 years each, expiring in rotation, two each year. Should a vacancy occur the governing council shall elect a member to fill such vacancy for the unexpired term. The terms of the members of the executive board shall begin at the end of the annual meeting at which they have been elected, and shall continue until the end of the annual meeting at expiration of term, provided that newly elected members of the board shall have the right to attend meetings as soon as elected, and shall have no vote until installed.

C. Reelection: After two consecutive terms of 3 years a member of the executive board shall be ineligible for reelection during one association year. This provision shall not apply to an officer of the association.

D. Officers: The executive board shall elect from its own membership a chairman who shall serve in that capacity for such term as the executive board shall determine. It shall also designate such other officers of the board as it may require for the conduct of its business.

E. Duties:

1. To direct the administrative work of the association.
2. To act as trustee of the association's properties.
3. To plan methods for the procurement of funds.
4. To recommend budgets for the association's work.
5. To conform to the policies of the governing council in the conduct of its work.
6. To appoint the members of the standing committees and to authorize and confirm the appointment of all other association committees.
7. To transmit a report of its proceedings and transactions to the governing council at least 30 days before each annual meeting.
8. In general to carry out the policies of the governing council between meetings of the latter.

F. A quorum of the executive board shall consist of the four members.

Article IV, Officers

The officers elected by the governing council shall be nominated from the floor by that body.

Article V, Committees

There shall be four standing committees of the association as follows:

1. Committee on eligibility.
2. Committee on administrative practice.
3. Committee on research and standards.
4. Committee on professional education.

A. Organization: All of the standing and special committees of the association shall be authorized and appointed by the executive board unless otherwise provided for in these bylaws. Unless otherwise provided for, all section committees shall be named by the respective sections, but the personnel of such committees shall be subject to confirmation by the executive board. The appointments of all association and section committees unless otherwise provided for in these bylaws shall expire at the next annual meeting. The chairman of the standing committees shall be designated by the executive board. The standing committees shall designate from among their membership such other officers as they may require for the conduct of their business. Each committee shall control its policies within limitations prescribed by the governing council and the executive board.

The executive secretary shall be a member, exofficio, of all standing committees, and shall serve as secretary of each such committee.

B. Composition and functions:

1. The committee on eligibility shall consist of one fellow to be elected by each section and an additional fellow elected by the executive board, the latter serving as chairman. Members shall serve for a term of 2 years.

This committee shall pass upon the eligibility of fellows, members and other constitutents in accordance with the provisions of the bylaws.

2. The committee on administrative practice shall consist of 15 fellows as follows: Twelve shall be designated by the executive board to serve for a term of 4 years, the terms of 3 members of this committee expiring each year. The remaining 3 members of this committee shall be elected annually by and from the fellows of the association, affiliated with the health officers section.

This committee shall engage in the collection of information regarding current public health practices and analyze the material obtained to derive standards of organization and achievement. The findings and standards may be made available to public health workers through publication, information, and field service under such conditions as the committee may establish. No standards shall be promulgated as the official and authorized judgment of the association except with the approval of the governing council.

3. The committee on research and standards shall consist of 15 fellows representative of the various sections of the association appointed by the executive board. Members shall serve for a term of 3 years, the terms of 5 members expiring each year.

This comittee shall be responsible for carrying out research and the development of standards in the technical branches of public-health service, and coordinate such research and standardization. This committee shall also be charged with the duty of reviewing from time to time standards already established. No standards shall be promulgated as the official and authorized judgment of the association except with the approval of the governing council.

4. The committee on professional education shall consist of 12 fellows appointed by the executive board. Members shall serve for a term of 3 years, the terms of 4 members expiring each year. This section shall become effective immediately upon its adoption. At that time all existing appointments to the committee on professional education shall expire. The executive board is authorized to appoint fellows to the committee to the number of 12 with terms so adjusted that 4 will expire annually.

This committee shall be responsible for carrying out research and the development of standards for professional education and training in public-health work and shall perform such other functions as may be delegated to the committee by the governing council with the view of maintaining professional qualifications of high standard. No standards shall be promulgated as the official and authorized judgment of the association except with the approval of the governing council.

Article VI, Meetings of the association

There shall be at least one annual meeting of the association held at a place to be selected by the governing council. Special meetings of the association may be called by a majority vote of the governing council, the executive board or the association. In all proceedings of the association Robert's Rules of Order shall be official.

Article VII, Sections

The executive board shall approve rules and regulations relating to the government of the sections, and to the appointment of administrative committees. Sections shall elect their own officers.

Nominating committee: The section chairman with the advice of the section council shall appoint a committee on nominations at least 15 days before each annual meeting. The section secretary shall be a member of such committee.

The names of the members of the committee on nominations shall be announced at the first meeting of the section at each annual meeting of the association. The committee on nominations shall present at the second meeting of the section a list of nominees for the section officers and for membership in the section council; provided that if the name of any fellow be transmitted to the nominating committee over the signature of 10 fellows of the section prior to the second meeting of the section, the nominating committee shall add the name of such fellow to its own list of nominees.

A. Officers of each section shall be a chairman, a vice chairman, and a secretary. The chairman, vice chairman, and secretary shall be the representatives of the section to the governing council of the association.

B. Terms: New terms begin and old terms expire at the end of annual meetings. After five consecutive years in any elective section office, except that of secretary, a member shall be ineligible to reelection to that office during one association year.

C. The chairman shall preside at meetings of the section.

D. The vice chairman shall preside at meetings of the section in the absence of the chairman.

E. The secretary of the section shall prepare the scientific program of the section for the annual meeting, subject to the recommendations of the section council, and he shall submit same to the administrative office and shall keep the minutes, and other records of the section, and shall transmit to the executive secretary of the association a copy of the minutes of both business and scientific sessions as soon as practicable thereafter. When unable to be present at meetings, he shall thoroughly instruct a substitute as far in advance of the meeting as possible.

F. Section council: There shall be a section council composed of the three officers of the section and five members, who shall be fellows of the section.

Terms of members of the section council shall be 5 years each. In the beginning one shall serve for 1 year, one for 2, one for 3, one for 4, and one for 5 years.

Duties of the section council shall be:

1. To recommend papers, and to make general recommendations in relations to the annual-meeting program.
2. To advise on section membership.
3. To advise on section policies.
4. To submit annually to the governing council through the executive board a report of the transactions of the section.
5. To report annually to the governing council through the executive board on the plans, scope, and policy of the section during the succeeding year.
6. To formulate rules of procedure for the section.
7. To approve and transmit to the governing council resolutions originating in the section.
8. To advise on the publication of papers and reports presented at the section meetings.
9. To advise with respect to the appointment of technical committees, subcommittees or section representatives on committees of the association.

Article VIII, Finances

All remittances to the association shall be deposited to the account of the treasurer. The treasurer shall be custodian of investments of the association and shall disburse funds in accordance with duly authorized vouchers. With the approval of the executive board he may establish a drawing account for the executive secretary, who shall send to members of the executive board a financial summary of receipts and disbursements each month. Once each month, or oftener if called for, he shall also forward to the treasurer and to the chairman of the executive board an itemized statement of all expenditures. The executive secretary and the treasurer shall be bonded at the expense of the association in an amount to be determined by the executive board. The books of the association shall be audited annually by certified public accountants, to be appointed by the executive board.

Article IX, Publications

All publications of the association and of its sections shall be issued under the direction of the executive board. The executive board shall appoint a managing editor of the official journal and an editorial board of not less than five members to serve at the pleasure of the executive board. All papers and reports for the annual meetings are to be accepted with the understanding that they shall be the property of the association for publication, unless this right is waived by the managing editor.

Article XI, Amendments

These bylaws may be amended by a two-thirds vote of those voting on the governing council during the annual meeting, provided that 24 hours' prior written notice thereof has been given. The bylaws may further be amended by a two-thirds vote of those voting at any meeting of the governing council called for the purpose, provided that notice thereof shall have been given at least 15 days prior to such meeting.

Senator SMITH. Is there anything else?

Senator DONNELL. There is nothing else.

(Subsequently with reference to the colloquy with respect to certain memoranda discussed by Mr. Falk, at the request of Senator Pepper, a covering letter and the memoranda referred to were submitted for inclusion in the record, as follows:)

JULY 24, 1947.

Mr. WATSON MILLER,
Federal Security Administration, Washington, D. C.

DEAR MR. MILLER: At the hearings conducted by the Senate Subcommittee on Health, yesterday, July 23, I asked Mr. Falk to read into the record documents from your files, which would indicate Mrs. Marjorie Shearon's attitudes on matters before the committee as of the period when she was employed by the Social Security Board.

The Senators present agreed that the documents should be read into the record. Unfortunately, just as Mr. Falk was beginning to read them, questions and comments were interjected and the committee adjourned before they could be read. As a result, my questions and requests will appear in the record unanswered unless the documents in question are promptly submitted.

Will you be so kind as to send them to me as soon as possible, in order that I may assure their insertion in the record at the proper point?

Sincerely yours,

CLAUDE PEPPER.

FEDERAL SECURITY AGENCY,
Washington 25, D. C., July 25, 1947.

Hon. CLAUDE PEPPER,
United States Senate, Washington 25, D. C.

DEAR SENATOR PEPPER: In compliance with your letter of July 24 I am transmitting to you herewith the official file copies of nine memoranda and a covering memorandum from Mr. I. S. Falk, Director of the Bureau of Research and Statistics, which identifies them as the documents he had before him and which he was requested to read at the hearing before the Health Subcommittee of the Senate Committee on Labor and Public Welfare.

In view of the fact that they are the official file copies, I should appreciate having them back for our files when they have served their purpose.

Sincerely yours,

MAURICE COLLINS, *Acting Administrator.*

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
July 25, 1947.

Interoffice communication

To: Mr. Harry N. Rosenfield, Assistant to the Administrator, Federal Security Agency.
From: I. S. Falk, Director, Bureau of Research and Statistics.
Subject: Memoranda prepared by Mrs. Shearon.

In compliance with your request for the documents which you advise me Senator Pepper is requesting, there are attached nine memoranda—eight prepared by Mrs. Shearon and one prepared jointly by Mrs. Shearon and Miss Klem.

These are the memoranda which I had before me when testifying before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare on July 23, 1947, and which I was directed by the chairman to read, in response to the question asked by Senator Pepper about Mrs. Shearon's attitude in 1938 toward the problems, policies, or materials involved in the drafting of specifications on medical-care programs. (I have not yet received the transcript and cannot be sure I am recalling precisely the wording or detail of Senator Pepper's question.)

There follows a list of the memoranda:

Notes on the specifications for a draft bill for public medical care (5 pages), September 12, 1938 (attached draft bill September 12, 1938) (10 pages) (MS).

Notes on the specifications for a draft bill for public medical care (4 pages), September 30, 1938 (attached draft bill September 28, 1938) (9 pages) (MS).

Discussion of the proposed draft of an amendment to the Social Security Act providing for a public medical-care program (9 pages), October 21, 1938 (MS and MCK).

Memo: MS to ISF re the draft bill for medical care and the covering memorandum (4 pages), October 28, 1938.

Memo: MS to ISF re comments on draft bill covering recommendations III and IV of the Technical Committee for Medical Care (1 page), November 2, 1938.

Memo: MS to ISF re compulsory national health insurance (1 page), November 2, 1938.

Memo: MS to ISF re medical assistance for the medically needy under the poor relief laws (5 pages), November 7, 1938.

Memo: MS to ISF re criticism of draft bill for medical care, dated November 9, 1938 (3 pages), November 12, 1938.

Memo: MS to ISF re proposed Federal Poor Law Act of 1939 (2 pages), November 14, 1938.

I. S. FALK.

September 12, 1938. M. SHEARON.

NOTES ON THE SPECIFICATIONS FOR A DRAFT BILL FOR PUBLIC MEDICAL CARE

This bill has been drafted on the following principles:

1. The provision of minimum medical services to all individuals requesting such services is a duty of government.

2. Any eligibility requirement for medical care involving a "means test" or determination of family income will be socially detrimental to any program of public medical care.

A very large portion of the population, although unable to meet the cost of medical care in the case of serious illness, is yet unwilling to accept public care if it is administered on a charity basis. Such persons, it is believed, will not apply for medical care, however much they need it, if they are compelled to undergo a social investigation and prove need.

3. If there is to be any restriction in the extent of the medical-care program, eligibility should be based on some requirement which is automatic and does not involve a social investigation of the recipient of such care.

a. It is proposed that public medical care be made available to:

(1) Recipients of relief, who are already identified and will require no further investigation at the time of receiving such additional assistance;

(2) Recipients of wages under Federal work programs, who are already identified by their pay-roll identification cards or otherwise;

(3) Persons covered by title II of the Social Security Act, who are identified by their account numbers; and

(4) Wives, husbands, and dependent children under 16 of persons specified in (1), (2), and (3) above.

4. Complete, Nation-wide coverage for public medical care can be effected by two methods operating simultaneously:

a. There can be added to the proposed draft bill a section providing for voluntary insurance for those individuals now excluded in the bill, namely, the self-employed, domestic workers, agricultural workers, and others excluded under section 210 of the Social Security Act;

b. The inclusion of excluded groups by amendment of the Social Security Act.

5. Not less than 80,000,000 persons (about three-fifths of the population) are probably in need of public medical-care services in view of the fact that over two-thirds of all families have less than $2,500 income in prosperous times and about 90 percent have less than that amount in a fairly unprosperous, but not a deep depression, years like 1935–36.

In presenting this draft bill I have so worded it that restrictions can be introduced without destroying the essential features of the bill. Thus, if it is desired to provide only a small amount of help at the beginning, coverage could be limited to relief recipients, recipients of wages under Federal work programs, and employees covered by title II, a total of possibly 50,000,000 persons. Spouses and dependent children of the last two groups could be denied public medical care at the start to keep coverage down although there is no logical defense for giving more benefits to spouses and children of relief recipients than to the corresponding dependents of employees who are paying taxes or of individuals working for wages on Federal work programs.

I have throughout the draft bill specified the Social Security Board as the Federal administrative agency, although it is quite possible the United States Public Health Service would be the more logical agency.

The draft bill does not specify the type of State agency to administer the act. I believe that regardless of the selection of the Federal administrative agency—whether the Social Security Board, the United States Public Health Service, or an agency to be created—State administrative authority should rest either with the Public Health Service or with a medical-care agency to be created. My reasons for this recommendation are:

1. A medical-care program is primarily a medical, not a social-work, responsibility and belongs logically under the jurisdiction of a medical agency rather than of a welfare agency.

2. Since neither the State public-welfare nor the State public-health departments in most States are equipped to handle a medical-care program, it would be advisable right from the start to strengthen and encourage the agency which is destined to administer the program eventually, i. e., the State public-health department.

It is to be noted that State welfare departments had neither experience in, nor personnel for, relief administration in 1933, but they did not hesitate to undertake the job when FERA was formed. The FERA program was put into operation almost overnight and during 3 years (1933–35); over $4,000,000,000 were spent by staffs with little experience. Could not a health organization—State, Federal, and local—make at least as good a showing?

3. The last, but by far the most important, reason for suggesting that the medical-care program be kept under the jurisdiction of a public-health or other medical group at the State level (and, of course, at the local level) rather than under welfare auspices is that the program will be blasted from the very beginning if, in the eyes of the public, it is viewed as a relief measure. A nonrelief family in most cases will not apply for a doctor, a nurse, a dentist, or hospitalization if this means going to the county or municipal welfare department. The stigma of charity is there and an employed, insured worker will see no reason for his being treated like a relief client. The so-called medically needed are not likely to receive much benefit from a public medical-care program if it is under the auspices of the welfare department.

In presenting this draft bill it is assumed that there will be a health insurance plan for wage losses due to temporary and to permanent disability. Provision must then be made for medical care either under an additional insurance scheme or by a grants-in-aid plan. Since there is already much dissatisfaction with the amount of pay-roll taxes to be collected in the years to come, and there is agitation for their reduction by the next Congress, we cannot well increase these taxes to provide medical care for insured workers. We can, however, kill two birds with one stone if we increase the benefits under title II to include medical care, thereby reducing the reserve fund and giving workers tangible, immediate returns for their tax payments. The Federal contribution for medical care for relief recipients may be paid for from emergency relief funds and the Federal contribution for workers on Federal work programs may be met from the respective funds now covering the pay rolls for those programs. Thus the Federal share for the medical care program will be met entirely from general taxes.

It is further assumed that title V of the Social Security Act will be invalidated when and if a comprehensive medical care program is adopted.

September 12, 1938. M. SHEARON.

[Draft bill]

A BILL To provide for and promote the general welfare of the United States by enabling the several States to make more adequate provision for individuals in need of medical care; to provide for the proper administration of this Act; and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—GRANTS TO STATES FOR MEDICAL CARE

APPROPRIATION

SECTION 1. For the purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, medical-care services to qualified individuals applying for such care, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of $400,000,000, and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Social Security Board, State plans for medical care.

STATE MEDICAL CARE PLANS

SEC. 2. (a) A State plan for medical care must (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide for granting to any individual, whose claim for medical care is denied, an opportunity for a fair hearing before such State agency; (5) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are found by the Board to be necessary for the efficient operation of the plan; (6) provide that the State agency will make such reports, in such form and containing such information, as the Board may from time to time require, and comply with such provisions as the Board may from time to time find necessary to assure the correctness and verification of such reports; and (7) provide for cooperation with medical, nursing, and welfare groups and organizations.

(b) The Board shall approve any plan which fulfills the conditions specified in subsection (a), except that it shall not approve any plan which imposes, as a condition of eligibility for medical care under the plan—

(1) Any residence requirement which excludes any resident of the State regardless of the shortness of time of residence therein; or

(2) Any citizenship requirement which excludes any citizen of the United States; or

(3) Any eligibility requirement for medical care other than that specified in section 6a.

ALLOTMENTS TO STATES

SEC. 3. (a) Out of the sums appropriated therefor, the Chairman of the Social Security Board shall allot to each State $500,000, and such part of $274,500,000 as he finds that the population of such State bore to the total population of the United States, in the latest calendar year for which the Bureau of the Census has available statistics.

(b) Out of the sums appropriated therefor, the Chairman of the Social Security Board shall allot to the States $100,000,000 (in addition to the allotments made under subsection (a)), according to the financial need of each State for assistance in carrying out its State plan, as determined by him after taking into consideration the population of such State.

(c) The amount of any allotment to a State under subsection (a) for any quarter remaining unpaid to such State at the end of such quarter shall be available to such State under section 4 until the end of the next succeeding quarter. No payment to a State under section 4 shall be made out of its allotment for any quarter until its allotment for the preceding quarter has been exhausted or has ceased to be available.

PAYMENT TO STATES

SEC. 4. (a) From the sums appropriated therefor and the allotments available under section 3 (a), the Secretary of the Treasury shall pay to each State which has an approved plan for medical care, for each quarter, beginning with the quarter commencing July 1, 1939, an amount which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Chairman of the Social Security Board shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is les than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such investigation as he may find necessary.

(2) The Chairman of the Social Security Board shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Chairman of the Social Security Board finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Chairman of the Social Security Board for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Chairman of the Social Security Board, the amount so specified.

(c) The Chairman of the Social Security Board shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under section 3 (a), and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Chairman of the Social Security Board.

OPERATION OF STATE PLANS

SEC. 5. In the case of any State plan for medical care which has been approved by the Social Security Board, if the Chairman of the Board, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is failure to comply substantially with any provision required by section 2 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

DEFINITIONS

SEC. 6. When used in this title—

(a) The term "qualified individual" means—

(1) Any individual who is qualified under section 210 of the Social Security Act or who may become qualified under amendments to title II of that Act, such individual to be considered as qualified from the time of entering employment as therein defined;

(2) Any individual who is in receipt of private organized relief or of Federal, State, or local relief;

(3) Any individual in receipt of wages under any Federal work program;

(4) The wife or husband or dependent child under 16 years of age of any individual qualified under section 6 (a) (1), 6 (a) (2), or 6 (a) (3).

(b) The term "medical care" includes—

(1) Diagnostic services;

(2) Medicine and appliances;

(3) Services of physicians in public hospitals and clinics, and in the homes of qualified individuals;

(4) Services of surgeons in public hospitals;

(5) Hospitalization, exclusive of the period of maternity, and of care of the tuberculous and mentally diseased;

(6) Bedside nursing care;

(7) Emergency dental care;

(8) Services of physicians and surgeons and hospitalization in nongovernmental hospitals wherever local conditions render this policy necessary or expedient.

TITLE II—GENERAL PROVISIONS

Sec. 201. (a) When used in this Act—

(1) The term "State" includes Alaska, Hawaii, and the District of Columbia.

(2) The term "United States" when used in a geographical sense means the States, Alaska, Hawaii, and the District of Columbia.

RULES AND REGULATIONS

Sec. 202. The Secretary of the Treasury, and the Social Security Board, respectively, shall make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions with which each is charged under this Act.

SEPARABILITY

Sec. 203. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act, and the application of such provision to other persons or circumstances shall not be affected thereby.

RESERVATION OF POWER

Sec. 204. The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.

SHORT TITLE

Sec. 205. This Act may be cited as the "Public Medical Care Act."

September 30, 1938. M. Shearon.

Notes on the Specifications for a Draft Bill for Public Medical Care

(RECOMMENDATION IV OF THE TECHNICAL COMMITTEE FOR MEDICAL CARE)

The bill has been drafted on the following principles:

1. The provision of minimum medical services to all individuals requesting such services is a duty of government.

2. Any eligibility requirement for medical care involving a "means test" or determination of family income will be socially detrimental to any program of public medical care.

A very large portion of the population, although unable to meet the cost of medical care in the case of serious illness, is yet unwilling to accept public care if it is administered on a charity basis. Such persons, it is believed, will not apply for medical care, however much they need it, if they are compelled to undergo a social investigation and prove need.

3. Ultimately public medical care should be available to every person requesting it and should be obtainable with as little red tape as is public education. A practical approach may necessitate the development of a public medical-care program in possibly three steps: First, the provision of such care only for the relief population of 20,000,000; second, provision of public medical care for the medically needy, including the relief population and some 20,000,000 nonrelief

persons in low-income groups near the relief level; and third, provision of public medical care for the entire population.

Under recommendation IV proposed by the technical committee the Federal Government will participate on a grants-in-aid basis in the medical care programs of the several States. Persons qualified for public medical care will be specified by the States. The Federal Government will not attempt to specify who are "qualified individuals," but after any State has established its criteria and has an accepted plan, Federal funds shall be made available on a variable grant basis.

4. In order to take account of the varying fiscal capacities and medical needs of the several States, it is proposed that grants-in-aid be apportioned according to (1) a formula indicating the relative fiscal capacity of each State as determined by objective criteria, (2) the number of individuals qualified for public medical care under the State plan, and, possibly, (3) a per capita maximum expenditure of $20, $30, or some other amount to be specified. There are serious objections to having a maximum per capita expenditure beyond which States shall not be reimbursed by the Federal Government. Whatever maximum is specified for Federal participation is likely, in theory and practice, to become the State maximum. Most States administering a grants-in-aid program are loath to spend State funds for additional or superior services, the costs of which will not be reimbursed by the Federal Government. Wealthy States that could furnish services well above the average for the country as a whole might be inclined to restrict their public medical care programs were Federal reimbursement limited to a low per capita expenditure, whereas, if States were reimbursed without limitation, they might become pioneers and set high standards which other States would try to emulate.

* * * * * * *

The State administrative agency in all cases has been specified as the "State health agency." This would be either an existing health agency such as the State public health department or other health agency or a new agency to be created to administer the public medical care program.

The fundamental principle is here accepted that a medical care program must be administered and supervised by health and medical groups and that State and local agencies must be health rather than welfare agencies for the following reasons:

1. A medical care program is primarily a medical, not a social work, responsibility and calls for medical knowledge, skills, and approaches.

2. Since neither the State public welfare nor the State public health departments in most States are equipped to handle a medical care program, it would be advisable right from the start to strengthen and encourage the agency which is destined to administer the program eventually, i. e., the State health agency.

It is to be noted that State welfare departments had neither experience in, nor personnel for, relief administration in 1933, but they did not hesitate to undertake the job when FERA was formed. The FERA program was put into operation almost overnight and during 3 years (1933-35) over $4,000,000,000 was spent by staffs with little experience. Could not a health organization—Federal, State, and local—make at least as good a showing?

3. A further important reason for stipulating that the medical-care program be kept under the jurisdiction of a health or other medical group at the State level (and, of course, at the local level) rather than under welfare auspices is that the program will be blasted from the very beginning if, in the eyes of the public, it is viewed as a relief measure. A nonrelief family in most cases will not apply for a doctor, a nurse, a dentist, or hospitalization if this means going to the county or municipal welfare department. The stigma of charity is there and an employed worker will see no reason for his being treated like a relief client. The so-called medically needy in the nonrelief group are not likely to receive much benefit from a public medical-care program if it is under the auspices of the welfare department.

4. Finally, it is essential that any program for medical treatment be closely united with existing and future programs for prevention of disease and of industrial and other accidents. Effective union of treatment and prevention is possible only under a single health agency.

* * * * * * *

No State shall be required to furnish medical-care services as part of the minimum services required under a State medical-care plan in this amendment if such services have already been developed under State plans approved under other titles of the Social Security Act.

Medical care for transients is to be provided either under a separate amendment to the Social Security Act covering general relief and medical benefits or under this amendment. The cost of such care may be borne in full by the Federal Government or may be shared.

[Draft bill]

September 28, 1938. M. SHEARON.

DRAFT BILL OF AN ACT TO ADD TITLE XIIIA TO THE SOCIAL SECURITY ACT

AN ACT To add title XIIIA to the Social Security Act, providing for and promoting the general welfare of the United States by enabling the several States to make more adequate provision for the health of persons in need of medical care; to provide for the proper administration of this Act; and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE XIIIA—GRANTS TO STATES FOR MEDICAL CARE

APPROPRIATION

SECTION A 1301. For the purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, medical-care services to qualified individuals applying for such care, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1939, the sum of $500,000; for the fiscal year ending June 30, 1940, the sum of $________; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Federal agency administering this act, State plans for medical care.

STATE MEDICAL-CARE PLANS

SEC. 2. (a) A State plan for medical care must (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State health agency to administer the plan or provide for the establishment or designation of a single State health agency to supervise the administration of the plan; (4) provide for granting to any individual, whose claim for medical care is denied, an opportunity for a fair hearing before such State agency; (5) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are found by the Federal agency to be necessary for the efficient operation of the plan (6) provide that the State health agency will make such reports, in such form and containing such information, as the Federal agency may from time to time require, and comply with such provisions as the Federal agency may from time to time find necessary to assure the correctness and verification of such reports; and (7) provide for cooperation with any State public welfare, public assistance, or public relief agency or agencies which may be vested with responsibility for the administration of general public welfare, assistance, or relief.

(b) The Federal agency shall approve any plan which fulfills the conditions specified in subsection (a), except that it shall not approve any plan which imposes, as a condition of eligibility for medical care under the plan—

(1) Any residence requirement which excludes any resident of the State regardless of the shortness of time of residence therein; or

(2) Any citizenship requirement which excludes any citizen of the United States; or

(3) Any eligibility requirement for medical care other than that specified in section 6 a.

ALLOTMENT TO STATES (SEC. 3). PAYMENT TO STATES (SEC. 4)

[These two sections cannot be written at this time because certain basic formulae have not yet been completed.

[It is proposed that the Federal agency administering this Act shall allot to each State sums determined under a system of variable grants which shall take account of:

[1. General fiscal resources of the State (to be ascertained according to formulae now being developed by several Federal agencies);

[2. Number of "qualified individuals" in the State; and

[3. A limitation of $20 per capita for costs of medical care to qualified individuals.]

[In other words, the Federal Government shall make to States with approved plans grants varying in accordance with the fiscal resources of each State and with the number of individuals qualified to receive medical care under the State plan. The amount paid to any State by the Federal Government shall not includue sums to reimburse said State for any expenditure which in the aggregate exceeds $20 per capita for medical care to qualified individuals during any fiscal year.]

(b) The method of computing and paying such amounts shall be as follows:

(1) The Federal agency shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than a specified percentage of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such investigation as he may find necessary.

(2) The Federal agency shall then certify the amount so estimated by it to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Federal agency finds that its estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Federal agency for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to such audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Federal agency, the amount so specified.

(c) The Federal agency shall from time to time certify to the Secretary of the Treasury the amounts to be paid to the States from the allotments available under section 3 (a), and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Federal agency.

OPERATION OF STATE PLANS

SEC. 5. In the case of any State plan for medical care which has been approved by the Federal agency, if the Federal agency, after reasonable notice and opportunity for hearing to the State health agency administering or supervising the administration of such plan, finds that in the administration of the plan there is failure to comply substantially with any provision required by section 2 to be included in the plan, it shall notify such State health agency that further payments will not be made to the State until it is satisfied that there is no longer any such failure to comply. Until it is so satisfied it shall make no further certification to the Secretary of the Treasury with respect to such State.

DEFINITIONS

SEC. 6. When used in this title—

(a) The term "qualified individual" means any individual who is qualified for public medical care under a State plan approved by the Federal agency.

(b) The term "medical care" shall include as a minimum, but not be limited to, diagnostic services; services of physicians and surgeons in their offices, in the homes of qualified individuals, in public hospitals and clinics, and in nongovernmental hospitals wherever local conditions render this policy necessary or expedient; hospitalization, exclusive of the period of maternity and of hospital or other institutional care of the tuberculous and mentally diseased, provided that such hospitalization shall be in governmental hospitals except where local conditions render it necessary or expedient to use nongovernmental hospitals; and emergency dental care.

The term "medical care" may also include prescribed medicine and appliances and home nursing care.

M. SHEARON.
M. C. KLEM.

October 21, 1938.

DISCUSSION OF THE PROPOSED DRAFT OF AN AMENDMENT TO THE SOCIAL SECURITY ACT PROVIDING FOR A PUBLIC MEDICAL-CARE PROGRAM

SCOPE OF THE NATIONAL-HEALTH PROGRAM

On February 14, 1938, the Interdepartmental Committee to Coordinate Health and Welfare Activities presented to the President the national-health program recommended by the Technical Committee on Medical Care. This program is designed to meet with reasonable adequacy existing deficiencies in the Nation's health services.

The Technical Committee embodied its conclusions in five recommendations containing the following provisions:

Recommendation I: Expansion of public-health services and provision of medical care for the period of maternity and childhood.

Recommendation II: Expansion of hospital facilities.

Recommendation III: Provision of medical care for persons with low incomes including both those in receipt of public assistance and those just above the relief level.

Recommendation IV: Provision of public medical care for recipients of public assistance and for self-supporting persons. (This is an alternate recommendation, embracing III and exceeding it in coverage.)

Recommendation V: Insurance against loss of wages during sickness. Provision would be made for cash benefits to insured persons during periods of temporary or permanent disability.

Recommendations I and II call for the expansion of existing health, maternal, and child-care services and of present hospital facilities by means of Federal grants-in-aid to the States. Recommendation V calls for health-insurance legislation to provide cash benefits to insured persons deprived of employment by reason of temporary or permanent disability.

Recommendation III provides medical care services including physicians' and surgeons' services; hospitalization, and nursing care services as the probable minimum for that portion of the population which constitutes the lowest third in economic status. The group comprises about 40,000,000 persons, including 20,000,000 in receipt of general relief, public assistance under the Social Security Act, and work relief wages, plus another 20,000,000 who, though self-supporting, are in families having an income under $800 a year. These 40,000,000 persons are unable to pay any appreciable part of the costs of their medical care.

In addition to this group in most dire financial straits there is another group of persons in families having annual incomes from $800 to $3,000 a year. Self-supporting persons in this income range are able to pay for some medical-care services, but are generally unable to meet the unpredictable and often excessive costs of serious or recurrent illnesses and of hospitalization. Furthermore, they usually cannot provide for adequate preventive services which, through early diagnosis, would lead to early treatment and the avoidance of many serious illnesses. But even in families with incomes over $3,000 a year, the cost of preventive medical care services and of treatment for serious illness often proves to be a great financial burden resulting in loss of savings and the incurring of debts.

Since the risk of economic distress as a result of illness is almost universal and may be said to affect upward of 90 or 95 percent of the population, the Technical Committee proposed that a general medical care program might be established to reach a larger portion of the Nation than the one-third with very low incomes. Recommendation IV provides that the Federal Government shall cooperate with States which set up programs of medical care for the self-supporting as well as for recipients of public assistance. Federal cooperation will take the form of grants-in-aid and payments will be made to States in accordance with their health needs, financial capacity, and certain other objective criteria. The States are free to decide whether or not they wish to pass legislation providing medical care and whether they prefer to have a health-insurance plan financed by contributions from employers, employees, and Government or a public medical-care plan financed from general tax funds. Regardless of the plan selected the amount of the Federal grant-in-aid will be the same for each State.

PRINCIPLES UNDERLYING DRAFT BILL

The proposed draft bill for public medical care is based on the following general principles:

1. Provision of minimum medical-care services to all individuals who cannot meet the cost of such services is a duty of government.

2. It is socially undesirable to have a "means test" to determine eligibility for public medical care.

3. The quality of medical care furnished will be of a much higher grade if Federal legislation includes among the persons qualified for medical care services both the self-supporting and those in receipt of public assistance.

4. Federal legislation shall be drawn with a view to shaping State legislation along socially desirable lines that will include:

a. Elimination of "means tests" for determination of eligibility for public medical care;

b. Equal medical-care services for all qualified persons including both the self-supporting and the recipients of public assistance;

c. Establishment under State health-insurance plans of State health funds into which shall be paid contributions by the State on behalf of recipients of public assistance as well as contributions by employees and employers.

5. Federal grants-in-aid are more equitably distributed to the various States on a variable, than on a fixed, matching basis.

6. Since a medical care program logically should be administered and supervised by health and medical groups, State and local administrative or supervising agencies should be health, rather than welfare, agencies.

7. Certain minimum medical care services should be specified in Federal legislation as a prerequisite for approval of a State plan and the granting of Federal aid. It would be unwise to leave the determination of minimum services to the discretion of any Federal agency because too much discretion left with a Federal agency inevitably results in pressures which are detrimental to the program as a whole.

COMBINATION OF RECOMMENDATIONS III AND IV

In the draft bill recommendations III and IV have been combined in such a way as to carry out the intent of the Technical Committee and at the same time to present a legislative program that will forestall many criticisms and will, it is hoped, stand up under the attacks of various interested groups.

The bill provides Federal grants-in-aid to States furnishing at least the specified minimum medical care services. The States may decide what portion of their population is to receive these services. In theory a State might decide to furnish public medical care to its entire population as it now furnishes public education. The Federal legislation should be so flexible that in that case the Federal Government would match the State expenditures for such services on the variable grant basis. During the next few years, however, probably only a few States will undertake to do more than provide medical care for the lowest-income groups. As administrative machinery is perfected and as popular demand for public medical care increases, coverage under State plans may be extended upward through higher and higher income groups.

PROVISIONS ON WHICH OPINIONS DIFFER

It is recognized that differences of opinion exist regarding several provisions and implicit or explicit exclusions in the attached draft bill, the most important of which probably are the following:

1. The provisions that a State medical care plan, whether health insurance or a general medical-care program should be in effect in all political subdivisions of the State.

2. The provisions that a State medical-care plan should specify, as a minimum, hospital care and the services of physicians and surgeons.
3. The omission of a provision limiting the receipt of medical care services to persons or families below a specified income level.
4. The omission of a provision specifying that transients are eligible to receive medical care services.
5. The combination of health insurance and public medical care.

DISCUSSION

State minimum coverage.—Those who do not accept the principle that a State medical-care plan should be in effect in all political subdivisions of the State believe that the State should be allowed to expend its available funds in those localities where facilities are most lacking, or where special medical needs exist, or if it seemed wiser, to concentrate all efforts upon improving the facilities in a few sections of the State as a demonstration of what could be provided on a State-wide basis with more adequate funds. Those favoring a State law in effect in all political subdivisions of the State believe that at least the minimum medical care services should be assured to all qualified persons. A mandatory provision would force the State to aid poor localities by means of equalizing grants, but would not compel the State to establish expensive facilities in sparsely settled areas where they were not needed. In general more adequate services would continue to be available in metropolitan centers than in rural areas, but the basic necessities would be available in all areas.

Minimum Specifications.—Those who are not in favor of State-wide coverage usually also oppose inclusion in the Federal bill of minimum medical services which the State would need to provide in order to receive Federal aid. They favor a bill which would leave with the Federal administrative agency the power to make individual arrangements with each State and which would allow for different minimum requirements in different States and in different parts of the same State. They visualize a plan which would be approved for a wealthy State under which quite complete care would be provided in metropolitan areas, less complete care in small cities, and very meager care, if any, in sparsely settled areas. They also visualize an approved plan for a less wealthy State which might be restricted to the provision of physicians' services in only part of the State. Those who favor approval of a State plan only if it is in effect in all subdivisions of the State, in general also favor the inclusion of minimum requirements. Without some specifications as to types of medical care services which must be provided as a minimum, some States may elect to push the hospital program while making no provision for medical care in the home or they may provide for the latter and neglect the former. Neighboring States, each receiving an equal reimbursement from the Federal Government, might be providing quite different types of care and it might result in some of the unfortunate situations which differences in relief budgets in neighboring States brought about under the FERA. A Federal bill specifying hospital care and physicians' and surgeons' services as a minimum might do much to extend the availability of care throughout the Nation and to redistribute medical practitioners.

Limitation to Specified Income Classes.—It is believed by some that a public medical-care program or a health-insurance plan should be limited to certain income groups, and that a Federal bill should include an individual or a family income level above which the State might not receive reimbursement for the medical-care services provided. Such an income limit is not provided in this draft bill because it is believed that the decision on this point should be left to the several States, and that the Federal Government should reimburse the States (according to the formula) regardless of the income ceiling adopted in each State. This is one of the most controversial points in connection with a medical-care program and difficulties are avoided by omitting it in the Federal bill and putting the responsibility upon the States. The Federal Government is protected against excessive demands for reimbursement by the States by the provision that total expenditures shall not be reimbursed when in any quarter they exceed $5 per person in the entire population at risk.

There is a danger that the minimum coverage (persons receiving public assistance and WPA earnings and the dependents of such persons) may tend to become the maximum, but even if this occurs during the first years of a State program the principle will have been established that the self-supporting and recipients of public assistance shall receive the same type of medical-care services under the State plan.

Transients.—The transients represent a group that is now denied public assistance by law and is denied the right to work on WPA jobs by common practice in the majority of States. The proposed draft does not include a provision for supplying this group with medical-care services because it is believed that (1) the transient problem might better be attacked as a whole and not piecemeal, (2) the task of selling health legislation should not be burdened by trying to sell other social legislation at the same time, and (3) inclusion of medical care for two or three hundred thousand transients might jeopardize a medical-care program affecting possibly 40,000,000 persons or more.

The combination of health insurance and public medical care.—The Technical Committee wished to give the States great latitude in the development of their State programs and to leave them free to elect the plan most adaptable to their requirements. It was believed that some States, particularly those primarily agricultural and rural, might find the method of payment through general taxation preferable; other States, more highly industrialized and urbanized, might find the insurance technique more generally applicable. The Federal reimbursement to the State is the same regardless of the plan adopted.

MEMORANDUM

OCTOBER 28, 1938.

To: I. S. Falk, Chief, Division of Health Study
From: Marjorie Shearon
Subject: The draft bill for medical care and the covering memorandum

Now that the draft bill for provision of medical care has taken definite shape and a covering memorandum has been prepared to point out what the bill is intended to do, wherein it falls short of its purpose, and what are the principles underlying this type of legislation, it becomes necessary for me to go on record in protest against both the bill and the memorandum.

The bill represents an earnest effort on the part of Miss Klem and myself to draft Federal legislation combining recommendations III and IV. What has been produced is a hybrid draft which attempts to please everyone and will probably end by pleasing no one. Weakened by vain compromises, it emerges in such form as to be wide open to attack both by its friends—if it finds any—and by its enemies. I believe the bill should be dissected mercilessly now, before it goes any further, and should be consigned to oblivion unless, perchance, it is to be presented as a horrible example of the sort of legislation that should never see the light of day.

The technical committee implied two fundamental principles as basic for a general medical-care program, namely,

1. Eligibility for medical care should not be determined by a means test.
2. Medical care for public dependents should not be separated from that for self-supporting persons. (Reaffirmed by Mr. Altmeyer.)

I am convinced that it is impossible to draft a single Federal bill for general medical care that will combine recommendations III and IV and will at the same time rest firmly on these two principles.

There are several places where irreconcilable provisions are demanded. First, under recommendation III it is necessary to provide for public dependents and for self-dependent persons with low incomes—two groups of approximately the same size (20 million each). In defining persons who are qualified for medical care—and we cannot sidestep definitions in order to escape dilemmas—we must specify the public dependents who are eligible and must also specify which self-supporting persons are to be eligible. How shall we specify them? If we say "all persons in families having incomes under $800 a year" or "all persons having incomes under $400 (or $500) a year," we immediately precipitate new questions and problems not the least of which is the question who, or what agency, is to determine the income of the individual or of the family?" Such income determination would almost of a certainty involve a social investigation and I think there is little doubt that this investigation would be made by the local welfare agency, that is, by a poor-relief official or some other welfare agent. This being the case, we have permitted, or have left the way open for, a means test to creep into the legislation and in so doing have contravened the first principle enunciated above.

It is to be noted that the draft bill as it now stands dodges this issue by failing to include in minimum coverage the 20 million self-supporting persons referred to in recommendation III. Such omission makes it possible to avoid the means test. Unfortunately, it also makes it possible for a State plan to provide medical care for public dependents only. And can we doubt that most States would follow just that course? Is it anything more than wishful thinking to assume that self-supporting persons in low-income groups will exert any pressure to secure for themselves such public medical care as may be provided to public dependents? Experience has shown that the poor who do not apply for public charity are not inclined to clamor for public services; indeed, they avoid with greatest care anything that bears the taint of public charity. Nay, more. There is slight hope that persons in this poorest self-dependent group will suddenly become vocal. They are too resigned to their fate to protest against unfair treatment. We who are engaged in drafting legislation and who see the weaknesses in what we are doing, have the duty, it seems to me, not only of pointing out the defects in our draft bills but also of championing the cause of those who are unlikely to show any solidarity in urging social legislation in their own behalf. If the bill is left as it is, the federally specified minimum coverage, applying to public dependents only, is almost certain to be the maximum coverage in the majority of States passing public medical-care legislation. And if by any chance a State should elect to provide such care for self-supporting persons with low incomes, there would surely be a means test to determine eligibility unless Federal legislation specifically excluded such a test from an acceptable State plan.

The real difficulty lies in the fact that public medical care, if it is really public, must be available to anyone seeking it. We do not furnish public education merely to children in families dependent on public support or in families having incomes below $800; we do not furnish public police protection or fire protection to relief and nonrelief families with incomes below $800. Yet we talk about "public medical care" that shall be given to at least a minimum group consisting of public dependents and we envisage a time when possibly self-dependent persons with incomes under $800 will enjoy such "public medical care" (presumably after signing a pauper's oath), and ultimately the time may come when the entire population will be able to have this care. The whole sequence does not make sense. Medical care supported wholly by general taxation is either "public," that is, free to all, or it is limited to certain needy groups in which case it must be regarded as "medical assistance" comparable to other forms of public assistance.

I believe it would be impossible to draft a Federal bill even for recommendation III alone without compromising on the means test. When, however, an attempt is made to combine recommendations III and IV in a single bill, the result is a hodge-podge of heterogeneous provisions that compromise not only on the means test but also on other fundamental social principles and make no contribution to legislation for a national health program. The hybrid bill is legally vulnerable, administratively impossible, and socially undesirable.

In the attempt to produce a bill within the framework of certain specifications there has been drafted what appears to me to be an indefensible document. Grants-in-aid are to be made to tates wishing to develop medical-care programs. The States may elect to develop insurance schemes or "public medical care" programs or combinations of both. In any event the Federal grant will be the same to any given State. This arrangement fails to take account of the fact that a real public medical-care program will call for a larger Federal subsidy than will an insurance scheme where the contribution by Government will be greatly reduced by reason of employer and employee premium payments.

Provision for coverage cannot logically have the same minimum under an insurance plan and under a public medical-care program. One can hardly conceive of a State setting up an insurance plan to provide medical care for relief and nonrelief persons with incomes under $800—the poorest third of the population. Consequently, any State desiring to provide medical care for the under-$800 group will provide what amounts to a medical assistance program presumably with a means test.

What this hybrid bill really attempts is a reconciliation of two irreconcilable concepts in a single document, namely, medical assistance for the needy, including relief and nonrelief low-income groups, and health insurance for employed persons with earnings above the subsistence level. Of course, this is not openly stated in the bill. But by failing to make positive provision that medical care under an approved plan shall not be limited to public dependents, by failing to exclude the means test as an administrative procedure, in other words, by a series of omissions, we have created a bill full of convenient loopholes for those who wish to circumvent social legislation.

Insofar as the covering memorandum is concerned, I am convinced that the true situation should be presented to Mr. Altmeyer and to Mr. Tate in plain straightforward statements not vitiated by softening and obscuring adverbs As a keen observer remarked in another connection, the nouns give and the adjectives take away. Speaking for myself alone, I must say that neither the bill nor the memorandum represents my best thinking on the subject. All the way through, the attempt was made to be on both sides of the fence at once and to avoid facing issues. I shall refer to only one or two sample items in the present memorandum.

Originally I wrote that a fundamental principle underlying Federal legislation for medical care was that "Provision of minimum medical-care services to all individuals who cannot meet the cost of such services is a duty of Government." The meaning is completely changed if this statement is altered to read that provision of such care is "a responsibility of society." I have elsewhere published at length a discussion of the break-down of society's efforts to provide for individual needs. Provisions made by the family and by friends, by employers, private charity, and voluntary insurance schemes have all proved inadequate. It is because society has failed to make adequate provision for the sick, the permanently disabled, the aged, and other persons unable to provide for their own needs that the aid of government has been invoked. It was because I wished to reaffirm this principle of the duty of government to take over the tasks that society cannot, or does not, assume that I stated the first principle in the memorandum as I did. To soft-pedal the issue by throwing the responsibility for medical care back into the laps of those whose voluntary efforts have already proved inadequate is to deny a principle I thought had been accepted by the socially minded.

In viewing the present draft, the one thing that impresses me most strongly is the way in which we have capitulated to the pressures of minority groups with vested interests. It is my opinion that we should recognize and formulate certain principles as fundamental in the provision of medical care and that we should be prepared to fight for them. Should there not be a line of last defense beyond which we will not retreat and for which we are willing to fight? I know you have done plenty of fighting, but in this particular bill and memorandum as now presented there is no sign of fight, only ignominous capitulation.

Nowhere in the memorandum is there to be found a clear and fearless statement concerning the real issues at stake. Dare we not voice them?

Is it too late to draft a genuine public medical-care bill? With 90 percent of the families in this country receiving less than $2,800 a year income, is it fantastic to suggest a Federal bill for public medical care supported from general taxation? If you believe that such a bill would have no backers, is it, then, too late to draft a national health insurance bill calling for compulsory insurance? This is the legislation demanded and favored by labor. It would avoid means tests and would enable Government to provide for relief and nonrelief persons living at or near the subsistence level by paying premiums on their behalf. National compulsory health insurance would furnish the only method—short of a nation-wide public medical-care program, which I think is sounder—of guaranteeing against stratification of the population into groups which would inevitably receive varying kinds and qualities of medical care according to their economic status.

* * * * * * *

I cannot do less than make my own position clear by this declaration of faith in the things in which I believe.

MARJORIE SHEARON.

MEMORANDUM

NOVEMBER 2, 1938.

To: I. S. Falk, Chief, Health Studies Division.
From: Marjorie Shearon.
Subject: Comments on Draft Bill Covering Recommendations III and IV of the Technical Committee for Medical Care.

Although my protests have thus far been in vain, I shall make this final statement as the draft is about to leave this Division.

I repudiate the bill as asocial and the covering memorandum as inadequate.

When Mr. Altmeyer, at Kansas City, laid down as a fundamental principle the undesirability of separating medical care for public dependents from that for self-supporting persons, did he intend to drag 110,000,000 persons down to the relief level or did he intend to raise 20,000,000 persons on relief to the level of self-supporting persons insofar as their receipt of medical care was concerned? Would the public conclude from Mr. Altmeyer's liberal statement that what he really contemplated, as a prerequisite for the receipt of tax-supported medical care, was an extension of means tests for virtually the entire self-supporting population? Has such a means test proposal ever been made anywhere before? Such legislation, if enacted, would call for invasion by a social worker, of the home of every person seeking so-called public medical care and would lead to such an inquisition of self-supporting persons as would be unthinkable in a relatively free democratic country like this.

We are not justified in calling the program we have outlined a public medical-care program; instead, we should call it by its true name—a medical-assistance program. The memorandum should point out far more clearly than it does the shortcomings of the bill and the places where tricky wording vitiates decent principles of social legislation.

I think it would be only fair to me to let Mr. Altmeyer and Mr. Tate know that I repudiate the bill and the memorandum. Whatever else I have accomplished since coming to the Board, I have built up a reputation for intellectual honesty and for social mindedness. This is the first time my name has appeared on a document that was intellectually dishonest and socially undesirable.

MARJORIE SHEARON.

MEMORANDUM

NOVEMBER 2, 1938.

To: I. S. Falk, Chief, Division of Health Studies.
From: Marjorie Shearon.
Subject: Compulsory National Health Insurance.

At our meeting yesterday you expressed surprise at my advocating compulsory national health insurance for medical care. I had in mind the Treadway bill introduced in the House of Representatives on March 14, 1938. That has always seemed to me a most desirable bill and I have wondered why it appears to have gone to sleep in the Committee on Interstate and Foreign Commerce.

This bill calls for health insurance "for every employee who is resident in the United States of America and whose rate of remuneration is not greater than $1,800 per annum." Dependents are included and the only exclusions are agricultural employees. employees exempted because of religious beliefs, and employees covered by industrial medical service plans. It is further provided that the income level may be raised to $3,000 if that seems desirable.

This is the sort of plan that not so long ago we were speaking of with admiration. It is almost a copy of the plan for British Columbia which was highly praised by Alan Peebles.

I cannot see that a few minor objections to a compulsory national health insurance bill should outweigh the great advantages of such legislation. We did not hesitate to force what was virtually national unemployment compensation simply because there were a few agricultural laborers who were temporarily excluded from coverage. I shall take up the agricultural bugaboo in another memorandum in which I shall discuss the various minor groups that might be excluded at the beginning from compulsory national health legislation.

It has been objected that Congress would oppose a bill calling for the establishment of any other Federal fund as a depository for contributions from employers and employees. In the case of medical care there is no possibility that a fund of any great size would accumulate because it would be drawn upon steadily for current expenditures.

What other valid objections are there to a compulsory national health insurance bill that would, more surely than any other legislation, bring about for the entire Nation the kind of medical care we say is desirable?

MARJORIE SHEARON.

MEMORANDUM

NOVEMBER 7, 1938.

To: I. S. Falk, Chief, Division of Health Studies.
From: Marjorie Shearon.
Subject: Medical Assistance for the Medically Needy Under the Poor Relief Laws.

Recommendation III of the Technical Committee does not provide tax-supported medical care for persons who cannot now receive such care but rather makes provisions for the sharing by the Federal Government of such public expense as is incurred for medical assistance. In considering the implications of recommendation III, it may be pointed out that the poor laws of nearly all the States accept responsibility for providing medical care for the sick poor. Undoubtedly the main reason that many of the sick poor have never accepted the aid available under the law is that the majority of the poor have a constitutional objection to being classed as paupers and to paying the social price for poor relief.

The social price for tax-supported indigent aid includes one or more of the following: (1) possible disenfranchisement as a pauper; (2) declaration of pauper status; (3) acceptance of State's right to make claim against pauper's property for relief furnished; (4) acceptance of State's right to make claims against legally responsible relatives; (5) registration of pauper in the "poor book" of the county; and (6) "farming out" or "contracting out" of paupers to the lowest bidder by local directors of the poor. I shall quote a few provisions from the poor laws now in force in various States.

ALABAMA

Claim against pauper's property. (1928 code, subsec. 27 of sec. I of the Poor Laws). "If any person who has received any relief, support, or maintenance at public charge, under this act or as an inmate of any State or county or municipal institution, was at the time of receiving such relief, support or maintenance, the owner of property, the authorities charged with the care of the poor of the municipality, or the board in charge of the institution chargeable with such relief, support, or maintenance, may sue for and collect the value of the same against such person and against his estate."

ARIZONA

Contract may be let or county may care for sick. (1928 Rev. Code, Ch. 16, 1936 Supp., sec. 811.) "That in each county of this State the care of the indigents of the county, including medical attendance, medicine, food, lodging, clothing, and other supplies shall be let to the best responsible bidder by the board of supervisors asking for sealed bids or proposals, * * *."

Affidavits to be made by persons seeking aid. (1928 Rev. Code, sec. 814.) "Any person not an indigent, who received hospital care, medical or surgical attention under the provisions of this act, shall be required to make remuneration therefor, insofar as he may be able. The reasonable cost of such service shall until paid be a debt due and owing the county; in case of the failure of a patient to pay the amount due and payable, it shall be the duty of the board of supervisors to furnish the county attorney of the county in which such county hospital is situated, a statement of the amount due and owing from such person, and thereupon it shall be the duty of the said county attorney to proceed to collect the amount in the same manner as other indebtedness due the county would be collected."

ARKANSAS

Health and medical aid. (1937 laws, Act No. 115, sec. 1.) "Any person whose income, or that of his family, does not exceed $30 per month from all sources, may, upon application to the county welfare director of the county in which such applicant resides, be certified by such county welfare director as being eligible for benefits under this act. Before any county welfare director shall certify any person as being eligible for benefits under this act he shall require a certificate from some licensed physician showing the physical condition of the applicant for benefits, and his need for hospitalization and medical care and treatment, and that he is not suffering from a contagious, venereal, mental, or tubercular disease. In addition to such certificate, the county welfare director may require such other proof as may be necessary to convince him that the applicant's physical condition is such as to need care and attention in some eligible hospital, and that the income of such applicant, or that of his family, does not exceed $30 per month."

IDAHO

This State provides that the board of county commissioners "may contract for the care, protection, and maintenance for the indigent sick, or otherwise dependent poor of the county." The board must employ a physician to attend, when necessary, upon the inmates of the poorhouse or county hospitals, and the board must also provide that persons at the county poor farm shall work to the extent of their ability as determined by the county physician.

Application for aid; form and procedure. (1932 Code, ch. 29, sec. 2904.) "Any sick or indigent person desiring aid from any county of this State must before said aid can be given, make a written application to the probate judge, the clerk of the board of county commissioners or to any justice of the peace in the precinct where such applicant may reside, setting forth and describing all the property, real, personal, and mixed, wherever it is situated, owned in whole or in part by such applicant, or in which he or she has any legal or equitable interest; if such applicant has no available property, real or personal, then he must declare his indigency and destitution, which must be signed by the party or parties making such application and sworn to before some officer authorized by the laws of this State to administer oaths, and filed in the office of the clerk of the board of county commissioners."

Application for cooperative assistance or relief. (Sec. 16, public assistance law.) "* * * The printed form of application shall contain a notice to the applicant of the right of recovery from him and his estate for assistance granted."

ILLINOIS

Who liable to support. (1931 Smith-Hurd, ch. 107, sec. 1.) "Every poor person who shall be unable to earn a livelihood in consequence of any bodily infirmity, idiocy, lunacy, shall be supported by the father, grandfather, mother, grandmother, children, grandchildren, brothers, or sisters of such person, if they are either of them be of sufficient ability."

INDIANA

Assistance of relatives. (1935 act, ch. 116, sec. 10.) "If the poor persons applying for township aid have relatives able to assist them who are living in the township, it shall be the duty of the overseer before giving them aid a second time, to call on such relatives of the poor person, and ask them to help their poor relatives, either with material relief or furnishing them employment."

Friendless needy sick. Providing for and burial. (1935 act, ch. 116, sec. 19.) "Provides that the overseer of the poor shall investigate and furnish necessary relief to any person within his township who is sick or in distress without friends or money. This section also provides that the overseer shall defray the funeral expenses of any person who dies within the boundaries of his township who does not leave money or other means necessary to defray such expenses and provides that the expenses shall be charged to the poor relief fund."

IOWA

Form of relief—condition. (1931 code, ch. 267, sec. 5322.) "The relief may be either in the form of food, rent, or clothing, fuel and lights, medical attendance, or in money, and shall not exceed $2 per week for each person for whom relief is thus furnished, exclusive of medical attendance. They may require any able-bodied person to labor faithfully on the streets or highways at the prevailing local rate per hour in payment for and as a condition of granting relief; said labor shall be performed under the direction of the officers having charge of working streets and highways."

Medical services. (1931 code, ch. 267, sec. 5323.) "When medical services are rendered by order of the trustees or overseers of the poor, no more shall be charged or paid therefor than is usually charged for like services in the neighborhood where such services are rendered.

Contracts for support. (1931 code, ch. 267, sec. 5334.) "The board of supervisors may make contracts with the lowest responsible bidder for furnishing any or all supplies, medical or dental attendance or services required for the poor, for a term not exceeding 1 year, or it may enter into a contract with the lowest responsible bidder, through proposals opened and examined at a regular session of the board, for the support of any or all of the poor to that effect, and shall require all such contractors to give bonds in such sum as it believes sufficient to secure the faithful performance of the same."

Medical and surgical treatment of indigents. (1931 code, ch. 199.)

Complaint. (Sec. 4005.) "Any adult resident of the State may file a complaint in the office of the clerk of any juvenile court, charging that any legal resident of Iowa residing in the county where the complaint is filed is suffering from some malady or deformity that can probably be improved or cured by medical or surgical treatment or hospital care and that neither such person nor persons legally chargeable with his support are able to pay therefor."

Duty of public officers and others. (Sec. 4006) "It shall be the duty of physicians, public health nurses, members of boards of supervisors and township trustees, overseers of the poor, sheriffs, policemen, and public-school teachers, having knowledge of persons suffering from any such malady or deformity, to file or cause such complaint to be filed."

Investigation and report by county attorney. (Sec. 4010.) "When such complaint is filed, the clerk shall furnish the county attorney and board of supervisors with a copy thereof and said board shall, by the overseer of the poor or such other agent as it may select, make a thorough investigation of facts as to the legal residence of the patient, and the ability of the patient or others chargeable with his support to pay the expense of such treatment and care; and shall file a report of such investigation in the office of the clerk, at or before the time of hearing."

KANSAS

Relief of the poor. (House bill 425, laws of 1933, ch. 196.)

"Sec. 1. The board of county commissioners shall administer the relief and aid of the poor and indigent who are unable to care for themselves.

"Sec. 2. That all such relief hereafter furnished shall be furnished only to those who have filed a proper application for poor relief with the poor commissioner, whose condition has been investigated, and who have been regularly budgeted to receive poor relief on the forms and in the manner prescribed by the board of county commissioners."

LOUISIANA

Support of infirm paupers. (Gen. Stats., ch. 12, sec. 6470.) "It shall be the duty of the several police juries throughout the State to provide for the support of all infirm, sick and disabled paupers residing within the limits of their respective parishes, except such as may reside in municipal corporations, either exempt or partially exempt from parish taxation; they shall adopt such measures as they may deem just and necessary to ascertain the names, situation and condition of all such, in order that they may provide for the entire support of the utterly destitute and helpless, and for the partial support or assistance of others, according to their circumstances and conditions."

SOUTH DAKOTA

Poor book. (1929 Comp. Laws, ch. 8, sec. 10043.) "Such county commissioners shall enter in the poor book all poor persons in their county who are unable to care for themselves, and who shall in their judgment be entitled to the benefit of the provisions of this chapter, together with the date of the entry."

TENNESSEE

Care and treatment of indigent sick and injured in hospitals. Quarterly courts may contract with hospitals for one or more beds. (Tenn. Code Ann., ch. 2, sec. 4823.) "For the purpose of caring for indigent sick or injured persons, the quarterly county courts of this State are hereby empowered to enter into contract with any reputable hospital, upon such terms as may be mutually agreed upon, for the care and treatment of indigent sick or injured persons, and make annual contracts with such hospitals for a right, on the part of the county, to the use of one or more beds in said hospital in which said county shall have the right to place patients for hospital treatment to be rendered by said hospital."

MARJORIE SHEARON.

MEMORANDUM

NOVEMBER 12, 1938.

To: I. S. Falk, Chief, Division of Health Studies.
From: M. Shearon
Subject: Criticism of draft bill for medical care, dated November 9, 1938.

Once again I protest. This revised bill is another sorry compromise, not so bad as the preceeding one but bad enough.

In an effort to carry out recommendations III and IV of the Technical Committee we have used a device that should be described clearly to the Technical Committee and to Mr. Altmeyer. The full implications of the use of this device should be set forth now while we are still discussing the social values of the legislation proposed.

The heart of this bill is in the definitions. The device we employed to meet recommendations III and IV was to define a "qualified person" under three possible medical care programs and in particular to redefine public assistance to include medical assistance. In other words, the Federal Government, under our bill, will call for a redefining of poor relief to include not only such commodities as groceries, rent, clothing, and coal, but also medical care services. Under the present poor laws it is generally recognized that the indigent sick are a charge on the community. Indigents under these laws cannot always claim medical care services in their homes, but they can usually go to the county poor farm or some other local institution that provides for sick papupers. Our proposal is that a State with an approved medical-assistance plan shall provide medical care services for declared paupers in their homes and in hospitals. We put a little more compulsion in the law than there is now; we insist upon home services; and we put a Federal definition of need into the legislative picture, whereas up to this time Federal legislation has left to local administrative agencies to determine what constitutes need.

The most important thing this definition does, however, is to lay down the principle that the self-supporting persons who needs the servies of a physician or surgeon for which he cannot pay may secure such services under the Federal plan by declaring himself a pauper. With one hand we hold out the hope of medical care for the millions who need it; with the other hand we drive those millions away.

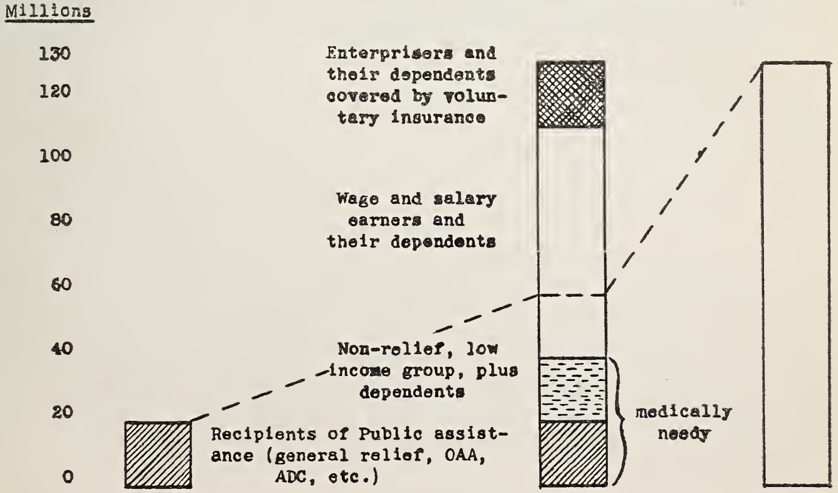
I have searched the Technical Committee report in vain to discover any place in which the statement is made that self-supporting persons must take a means test to enjoy the benefits of the Federal medical care plan.

It is assumed by those who want the means test for self-supporting persons with low incomes that this group must be linked with the group of persons now in receipt of public assistance. We do not cut through the coverage in other social insurances in this fashion. We do not say that nonrelief persons in families with incomes under $800 or $1000 must seek unemployment relief instead of building up unemployment insurance rights or that they must look forward to accepting old-age assistance instead of old-age insurance benefits. Why make this stratification among wage earners seeking medical care?

Will we not meet all the requirements of recommendation III if we say that the 20,000,000 self-supporting persons with low incomes are to receive medical care under health insurance instead of under medical assistance? We are leaving it to States to decide which program they will adopt. Is there any justification for taking a big group of wage earners and suggesting that they be cared for under medical assistance instead of under health insurance. We have not followed that procedure in other social legislation.

The following tripartite proposal for medical care would incorporate all proposals in recommendations III and IV but would link the 20-million non-relief, low-income group with insurance instead of Assistance.

MARJORIE SHEARON.



MEMORANDUM

NOVEMBER 14, 1938.

To: I. S. Falk, Chief, Division of Health Studies.
From: Marjorie Shearon.
Subject: Proposed Federal Poor Law Act of 1939.

Since we seem to be giving serious consideration to a Federal Poor Law Act that is definitely to include medical relief (or medical assistance) for the "otherwise self-sustaining," I should like to suggest that the law be clearly and forthrightly labeled what it is. Such a procedure will make clear beyond any doubt to the general public and the medical profession that the United States contemplates following in the footsteps of the British.

In Great Britain the administration of poor relief is governed for the most part by the Poor Law Act of 1930 which consolidated a number of earlier acts, ranging from the Poor Relief Act of 1601 to the Poor Law Act of 1927.

If we attempt to carry out recommendation III by furnishing medical assistance to the "medically needy" we shall find it necessary to adopt the principles now clearly set forth in the British Poor Law Act. It is there set forth that "by destitution is meant the absence of material resources necessary for satisfying basic physical needs. But a person may be regarded as destitute who is in need of some particular necessity of life without being destitute in all respects. Thus, for example, a person who is not entirely lacking in the means of subsistence, may yet be destitute in that he is unable to provide for himself the particular form of medical attention or treatment of which he, or some member of his household, is in urgent need."

It is to be noted that over one-third of the persons in Great Britain who were in receipt of domiciliary relief on January 1, 1936, were relieved on account of "sickness, accident, or bodily infirmity." These were the "otherwise self-supporting" who took advantage of medical services under the British poor law. With respect to this law the following statement is made in the Report on the British Social Services: "It is the duty of every public-assistance authority to provide medical attention for those who apply to it for relief, even if they are not destitute in the ordinary sense of the term. For this purpose a special domiciliary medical service has been created by appointing a medical officer in each district whose duty it is to attend and supply medicines to all poor persons requiring medical attendance within the district, at the order of a relieving officer."

If this is the sort of medical care program that the National Health Conference contemplated, the legislation should be identified as poor relief legislation and should be publicized in that way so that Congress and the public may have no doubt about what is contemplated.

MARJORIE SHEARON.

Senator SMITH. The committee will stand adjourned subject to the call of the chairman.

(Whereupon, at 12:40 p. m., July 23, 1947, the subcommittee adjourned. subject to the call of the chairman.)

NATIONAL HEALTH PROGRAM

TUESDAY, JANUARY 27, 1948

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to call, at 10 a. m., in the committee room, Capitol Building, Senator H. Alexander Smith (chairman of the subcommittee) presiding.

Present: Senators Smith (presiding), Donnell, Murray, and Pepper.

Senator Smith. The committee will please come to order. On July 23, prior to the adjournment of Congress, we were engaged in these hearings, and at that time I think Dr. Falk was on the stand. Before we call Dr. Falk for further examination I want to make a brief statement for the benefit of the committee and for the record.

After we adjourned last July, and after consulting with my colleagues on the committee I decided to send a letter to the governors of our 48 States, together with both of the bills, so that they could give us their judgment and explain briefly their comprehension of the bills. That letter was sent on August 7, and we have had replies from, all told, 39 of the governors of the various States. Thirty-nine States have replied.

I am going to insert in the record at this point the text of my letter addressed to the governors, and the questions that were asked them in that letter, and I then am going to insert in the record the replies, because I believe they indicate in a general way what the situation is in the various States, whether there has not been as much attention given to the health problem as possibly there should have been; and they give us as a committee a lead as to what might be called the "vacuums" in this field, and where the most advanced work has been done. So I am going to put the letters into the record and have them available to anyone studying this matter. Also I am going to insert in the record an analysis made by Mr. Melvin W. Sneed, who is staff advisor of the committee in the field of health. The analysis made by him shows simply the number of governors who replied and the general nature of their replies to the letter.

I would also like to introduce into the record, so we will have everything here, a communication which was sent out by Mr. Gael Sullivan, executive director of the Democratic National Committee, criticizing the letter that I sent to the governors, and implying that it misrepresents the facts. I think Mr. Sullivan is wrong about that, because in sending my letter to the governors I consulted with my colleagues, and we tried to put in the letter a brief presentation of what the respective bills stood for, but beyond that we sent the full text of the bills, so there could be no misrepresentation of the facts. Both bills, S. 545 and S. 1320, were sent to them so they could be thoroughly studied and we could get the benefit of the judgment of the various governors on the bills, and their analysis could help us in working out our problems. I just want the record to show what has been received from the governors in this connection.

Senator MURRAY. Mr. Chairman, I should like the record to show, that in my opinion, the letters from the various governors should in no way influence our consideration of the two bills before us, not even those from governors who expressed opinions in favor of S. 1320.

I say this for the following reasons:

(1) The letter sent to the governors was not cleared with the minority members of this committee before being sent. In our opinion the brief descriptions given both S. 1320 and S. 545 are unquestionably misleading as regards the contents and implications of both bills. I assume that this was inadvertent. I know it could have been avoided had the sponsors of S. 1320 been permitted to add their own characterizations of the bills.

(2) The letter gratuitously misdirected the governors by suggesting that their opinions be formulated by the medical authorities of the various States. On this point I feel quite strongly. Neither S. 1320 nor S. 545 primarily affects the practice of medicine. Both bills, on the other hand, have to do with the way in which people pay for medical care. Yet it was suggested that the governors allow their opinions to be formulated, not in consultation with the people who pay for medical care, but in consultation with State health officers whose own programs depend upon the good will of the local politicians of organized medicine. Insofar as the answers received reflect the opinions of State medical societies rather than of the people, they are biased and misleading.

Furthermore, I should like to point out that I know of no governor who has been in any way authorized to speak for the people of his State on this subject save one. The only governor who is justified in so speaking is a man who ran for the governorship on a platform involving compulsory health insurance. That Governor, Republican Gov. Earl Warren, of California, was elected by promising to support a health insurance bill. It might be pointed out, incidentally, that Governor Warren's pledge to the people of California was frustrated by a Republican-controlled legislature, a phenomenon we are not unfamiliar with on the national scene.

As far as my own State of Montana is concerned, I myself, was elected by the people of the State to help represent them in all matters involving national legislation—elected, I may add, with the full knowledge of the people that I was in favor of a national health insurance program and opposed to charity medical care. The Republican Governor of our State has not been authorized, and is in no way competent, to represent Montanans in matters having to do with Federal legislation in general, or with health insurance in particular.

It is for these reasons that I am compelled to regard this whole matter as politically motivated, altogether lacking in objectivity, and unworthy of serious treatment.

Senator Smith's own State of New Jersey illustrates the situation well. We had already learned that the doctors of that State are opposed both to my bill and to Senator Smith's own bill, S. 545, insofar as it applies to New Jersey. We know, too, that the millions represented by New Jersey's American Federation of Labor and New Jersey's Congress of Industrial Organizations were and are unalterably opposed to S. 545 and wholeheartedly in favor of S. 1320. Although it is refreshing to find that the Republican Governor of New Jersey is "not enthusiastic about S. 545," the fact that he is opposed to S. 1320 obviously does not reflect the attitude of the people of New Jersey.

Senator SMITH. I might say, Senator, that he is opposed to any Federal legislation. He thinks the matter ought to be handled by the States. I might point that out to you as you make your statement.

The question to me is whether the Federal Government should take these matters over from the States, irrespective of what the States think they want and simply say: "Disregarding your views or the views of your organizations, your governors and what not, we are going to impose legislation on you." That is one of the issues and we have got to face it.

I welcome your statement, Senator, because it brings out the differences between us. I think it is a fine way to do.

Senator MURRAY. My statement is to the effect that he is not enthusiastic about S. 545.

Senator SMITH. He doesn't want either one of them.

Senator MURRAY. That is an extract taken from his statement. The fact that he is opposed to S. 1320, obviously does not reflect the attitude of the people of New Jersey.

Had the chairman of this subcommittee sent copies of both bills to organizations of doctors and of the people in each State and requested their considered opinions on the two bills, I am sure he would have found the same thing as we have found in New Jersey. Organized medicine in each State would oppose S. 1320 and prove captious in its support of S. 545. The people in each State would denounce the charity plan and the bureaucratic horde of snoopers envisioned by S. 545 and would endorse national health insurance.

After all it is the people, not the doctors, who pay for medical care. Should we not ask the people how they'd like to?

That is the end of my statement.

Senator SMITH. I am very glad to have it included with the exhibits, because it brings out Senator Murray's position. We are good friends and he shows a fine spirit. The difference is fundamental on how this matter should be treated.

Senator MURRAY. That is right.

Senator SMITH. It is my belief that it could be better treated by over-all Federal direction, and I believe up to the moment—I have not made any final decision on it, but I believe that we have to use our States and we can't do better than use the set-up of the legally elected organizations in the States if we are going to work out a satisfactory program. We cannot have an arm of the Federal Government coming in and trying to override our local State governments, and from that angle I feel that the replies of these governors are very significant. I am perfectly willing to make further investigation. I will be glad to go along further with Senator Murray in getting more facts, rather than rushing through legislation that is not going to be effective. This is a very important project and we have got to decide how we are going to deal with the health of our people, and we are trying to get every possible angle. I have been advised that the Brookings Institution has been making a study of the matter this summer, and presently they will have a report of the observations which they have made, entirely on their own. I have had nothing to do with it. They have gone ahead on it themselves and they will be here to give their report and what they find in the different States with regard to the need of legislation, and so forth.

I have not seen the report yet. I have just been told that it is in the making, so that will be a helpful contribution to what we are trying to do. We may have to come to the issue of whether the Federal Government should take over from the States their right to run themselves. We are getting too far into the Federal field and we are not recognizing that we do have 48 sovereign States in this country that ought to have some knowledge of what they need in their respective jurisdictions. I want to make that statement as forcefully as I can, because that is where I fundamentally disagree with Senator Murray's position.

Senator Murray. Mr. Chairman, I might add that there has been so much propaganda put out in the country against this proposed legislation—

Senator Smith. And for this legislation.

Senator Murray. Yes—the propaganda being designed to create the impression in this country that this legislation is socialistic. I want to say that one of the common arguments against a national health insurance act is that it is socialistic in character. I want to present a further statement in this connection, and I would like to have it introduced in the record, showing that all of this kind of legislation that has been advanced in this country has been opposed and attempts made to block it by those who have an interest in blocking it, and in fact that all progressive legislation that has ever been offered in the history of this country has had to go up against the same kind of propaganda. I would like to have this in the record.

(The paper referred to is as follows:)

THE ALLEGED SOCIALIST CHARACTER OF THE NATIONAL HEALTH INSURANCE ACT

Lessons From American History

PROGRESSIVE LEGISLATION GENERALLY ASSAILED AS SOCIALISTIC

One of the common arguments against the National Health Insurance Act is its alleged socialist character. My reading of American history persuades me that there is hardly a piece of progressive social legislation that wasn't at one time or another attacked on the same grounds. A few illustrations make highly illuminating reading.

WORKMEN'S COMPENSATION

Take workmen's compensation, which we all accept today as a vast improvement over the old liability law. Some of us can remember that when the States early in the present century began to adopt workmen's compensation legislation, the opposition proclaimed from one corner of the land to the other that private property and individual liberty were threatened and that socialism lay around the corner.

Arguing the constitutionality of the State of Washington law before the Supreme Court in 1917, one employer said: "If the centralized advantages of communism or socialism are deemed preferable, the Constitution provides a method of amendment resulting in certainty of right. The act takes the employer's property without legal reason, invades his and his employee's right of private contract in a matter with which the public has no concern" (1. *Mountain Timber Co.* v. *State of Washington*, 243 U. S. (1917), pp. 223, 226).

The National Association of Manufacturers, then as now, a center for the most reactionary forces in America was opposed to workmen's compensation, just as it has since opposed every progressive measure advocated by the American people. It fought all decent labor legislation; it fought all tax measures designed to place the burden on those best able to carry it; and even after the crash of 1929, it fought the proposal to create the Securities and Exchange Commission. Then, as now, it fought deviously—always proposing a "voluntary" mechanism as a last resort when the people were determined on effective legislative action.

Just as today we see voluntary health insurance is suddenly espoused by the opponents of National Health Insurance, back in 1910 at the annual convention of the National Association of Manufacturers one of the speakers advocated voluntary workmen's compensation. He said, "This country is not keen for Government by paternalism and the people generally are not in favor of having the Government engage in the transaction of any business which corporate organization of private capital can satisfactorily serve, or perform any function which can be properly performed by individuals or associations. As the New York commission again says:

"Unless the whole workings of compensation shall ultimately rest in a new and extended bureaucracy, opposed alike to American habits and American constitutions, that problem must be worked out by mutual associations of employees encouraged by the employer" (2. Henry L. Rosenfeld, Cooperation and Compensation versus Compulsion and Compromise in Employers' Liability, Proceedings of the Fifteenth Annual Convention of the National Association of Manufacturers, 1910, p. 176).

PUBLIC EDUCATION

Tax-supported public education is regarded today as the birthright of every American. One hundred years ago the opponents of free education called it socialism. They said it was unjust to have the so-called better classes pay taxes for the education of poor children. "Why should the thrifty pay for the shiftless," they asked. In New York, the law for tax-supported schools was declared to be "infidel socialism in its principles; unjust and oppressive in its operation; immoral in its tendency, irreligious in its consequences, and injurious to the cause of education" (3. Frank Tracy Carlton, Economic Influences Upon Educational Progress in the United States, 1820–1850, Bulletins of the University of Wisconsin No. 221, 1908, pp. 60–61, 64).

When the Virginia Legislature in 1816–17 was considering the subject of free education, a local newspaper printed a letter from a reader which went in this vein:

"The bill assumes that Government ought to take the business of education into its own hands, not only for primary schools for the poor * * * but for all classes. Is it very clear that Government ought to do this? Have the practical effects been beneficial elsewhere? * * * Great men of Europe have been produced by the tutorial scheme wherein individuality is developed."

Another writer protested the proposed change from private initiative to compulsion by the State. The effect of education, he said, would be to diminish incentives for the development of work habits and of skills and to encourage sloth and idleness. He submitted a counter-proposal to establish a university and to provide funds for academies and colleges but which excluded all provision for primary schools which, he argued, the commonwealth did not need. "It is the duty of the Government," he said, "to supply only that which the citizens cannot provide in a private capacity" (4. William Arthur Maddox, The Free School Idea in Virginia before the Civil War, Contributions to Education No. 93 (Teachers College, Columbia University), 1918, pp. 69–71).

INCOME TAX

When Congress in 1894 debated a tax on income, many were the voices raised to assail such a tax as socialist and un-American. "It is an insidious and communistic leveler," said Representative Baker of New Hampshire, "which exact sufficient penalty from the thrifty, sober and laborious to make up for the delinquencies of the idle, dissolute and improvident. It is a tax which is sectional in its worst form, because its burdens will be discharged in a very large degree by a few States and a small section of the country" (5. Congressional Record, vol. XXVI, pt. II (House), p. 1298).

Representative Adams of Pennsylvania described the income tax as a "tax so odious that no administration ever dared to impose it except in time of war; and you will find that the people will not tolerate it in time of peace. It is unutterably distasteful both in its moral and material aspects. It does not belong to a free country—do you wish to put a tax upon thrift and impose a penalty on success? Do you desire to offer a reward to dishonesty and to encourage perjury? The imposition of the tax will corrupt the people. It will bring in its train the spy and the informer. It will necessitate a swarm of officials with inquisitorial powers. It is a direct step toward centralizaton" (6. Congressional Record, vol. XXVI, appendix, pt. 1, p. 207).

Said Representative Hendrix of New York: "It does violence to one of the cherished rights of citizenship in a free republic—the right of complete noninterference. It slaps the fact of public opinion, insults every democratic tradition, disrespects the sacred sentiment of personal liberty, and commits the party to one of the most vicious of political tendencies, the division of the community into classes" (7. Congressional Record, vol. XXVI, pt. IX, appendix, pt. 1, pp. 395–396).

"Should this bill pass," said Representative Milliken of Maine, "four-fifths of the taxes due will never be collected, and a comparatively few honest men will bear almost the entire burden. It necessitates a great army of official espials into the private business of the people, which is offensive to the American spirit of independence" (8. Congressional Record, vol. XXI, pt. IX, appendix, pt. 1, p. 306.

POSTAL SAVINGS

When a postal savings system was first suggested in the Theodore Roosevelt administration, the American Bankers Association passed a resolution condemning "as unwise and hurtful all propositions to establish postal savings banks." "I tell you," said one speaker, "it is entering upon a plan that a free and enlightened nation ought never to touch. Such vast deposits will be the football of politicians and an entering wedge to that deadly peril, paternalism" (9. Proceedings of the thirty-fourth annual convention of the American Bankers Association, 1908, pp. 294, 304).

STATE BANK DEPOSIT INSURANCE

Another speaker at the same convention, said about a proposal to guarantee bank deposits, "What can be more socialistic in its tendency, more paternal in its purposes, than this wild and illogical scheme and bank-deposit guaranty?" (10. Ibid., p. 281).

FEDERAL RESERVE SYSTEM

Even that essentially conservative piece of legislation establishing the Federal Reserve System did not escape the socialist tag. At the 1913 meeting of the American Bankers Association, the chairman of the association's currency commission said: "There are a great many different kinds of socialism; but, however the various theories differentiate, they all agree upon the fundamental proposition that the Government * * * should own * * * all money-making utilities * * *. For those who do not believe in socialism it is very hard to accept and ratify this proposed action on the part of the Government" (11. Proceedings of the thirty-ninth annual convention of the American Bankers Association, 1913, p. 79).

Another speaker prophesied state control of all corporations. "If such a forced contribution of the savings of our people invested in the business of banking can be useful, how long before every other form of corporate investment will be subjected to like disposal? And if part can be forcibly taken on the plea that it is for the general good, why not take the whole?" (12. Ibid., p. 83).

Like some physicians today, yesterday's bankers feared lay control. "It will readily be recognized that men trained in the banking business and conversant with the necessities of the borrowing public, as well as its ability to liquidate its obligations, could act with better information and clearer judgment than political appointees selected along partisan lines, and with only casual regard for their experience in the business," said the vice president of the American Bankers Association, "a business of such great magnitude and importance to the country's prosperity should be in the control of men educated and trained in such business in the highest degree, rather than in state control. This is not in any sense a political question. It must be solved upon the higher plane of statesmanship and not subjected to the strife and selfishness of political parties" (13. Ibid., p. 62).

Health insurance is now added to the list of so-called socialistic proposals. It is in good company.

Senator SMITH. I would just like to add that there is a great deal of propaganda both ways. There are two schools of thought in America today. One is that we must have more direction by the Central Federal Government over all our activities; the other is that the States still have intelligence to enable them to run their own affairs locally. I belong to the second class, and I think the burden of proof is on those who want to take away from the States their jurisdiction in these matters. If it can be demonstrated that there is some wide lack of care for our people, let us have the information. I have not seen it yet. It may be shown before we get through. But I certainly believe in recognizing the autonomy of our 48 independent States. It is time we began to study that more carefully and realize why their econômy was kept when our Constitution was set up. We are getting into all kinds of jams trying to put the hands of the Federal Government into the States to run their affairs wherein they have the responsibility, and I cannot imagine any governor of a State being so stupid or unfeeling as not to be interested in the health of his people. He never would be reelected if he showed any evidence of that, and to say that we can bypass the judgment of our 48 governors to my mind just does not make sense in this connection—with all due respect to my good friend, Senator Murray. As I say, I welcome his views, but let us have them out in the open. Let us get down to the fundamentals of the thing and understand what this is all about. If they want something like that, they can very easily determine it because we have elections every now and then and support the people that we believe in, so far as the issues are concerned.

Senator MURRAY. I appreciate the attitude taken by the distinguished chairman of this subcommittee. The argument he advances is the same argument advanced against every progressive piece of legislation we have had in this country. We had the same attitude with reference to the workmen's compensation law, the same attitude with reference to protection of children, the same attitude with reference to everything that we have had to fight for in this country for the welfare of the people.

Senator SMITH. Might I ask the distinguished Senator whether he looks upon Mr. Baruch's position as in favor of Federal industrial health insurance?

Senator MURRAY. He is in favor of the program we have presented in S. 1320.

Senator SMITH. I didn't notice that he endorsed that particular bill. I thought—however, I don't need to say that, because his speech in full will speak for itself. We will leave that to the reader to determine what his position is.

Now, Senator Donnell, will you proceed with the witness?

(The correspondence submitted by Senator Smith follows:)

AUGUST 7, 1947.

MY DEAR GOVERNOR: One of the most important matters before the present Congress has been the consideration of a national health policy which will bring about a wider medical service to meet the health needs of our people.

To the end that this subject might be fully investigated, a subcommittee of the Senate Committee on Labor and Public Welfare has been studying the subject for some months. This subcommittee is composed of the following Senators: Senators Ball, Donnell, Pepper, Murray, and myself as chairman.

In the course of our investigation and hearings, two fundamentally different approaches to the matter have been presented and considered. These respective approaches are covered by bills that were introduced in the Seventy-ninth Congress and by bills introduced in the Eightieth Congress. Extensive hearings were held last year on the Wagner-Murray-Dingell bill which was one of the measures introduced in the Seventy-ninth Congress. Extensive hearings have this year been held on S. 1320 introduced in the Eightieth Congress by Senator Murray and others, which bill is the successor of the so-called Wagner-Murray-Dingell compulsory health insurance bill, and on S. 545 introduced by Senators Taft, Ball, Smith, and Donnell.

Supporters of S. 1320 contemplate a Nation-wide tax collected by pay-roll deductions of workers in industry, and other taxes on non-pay-roll citizens, in return for which tax the Federal Government assumes responsibility for the over-all medical care of all the people. Provision for certain decentralization of administration is made in the bill.

S. 545, on the other hand, contemplates Federal grants to the several States and challenges the States to develop their own programs for taking care of the health needs of the people within their respective jurisdictions. No special earmarked tax is proposed under the plan.

Among the important questions which enter into the consideration of the bills are:

(1) What percentage of the population in the various States is not getting adequate medical care today; and what classes—that is, the very poor, the white-collar class, etc.;

(2) What States would approve a compulsory tax plan such as S. 1320 calls for, with a Government-supervised medical service; or

(3) What States would prefer the S. 545 plan, leaving to the States the determination of policy—that is, compulsory or voluntary group health plans, etc.

Our subcommittee would be very much aided if we could have a statement covering the situation in your State on these matters, which I assume could be prepared by the health authorities. I should add that under either plan Federal grants-in-aid are contemplated. Under S. 1320 the Federal tax would cover the entire cost, whereas under S. 545 a matching program is contemplated. Copies of S. 545 and S. 1320 are enclosed.

Also as related to these problems, I would appreciate information as to the situation in your State with regard to the following matters:

(1) How you handle the health problem in your widely scattered rural areas.

(2) How the new Federal aid to hospitals program is working.

The assistance of our 48 States with respect to this important matter will be greatly appreciated and I hope you can give us an outline of the situation in your State. In making this request I am acting in the spirit of what I understand is the position of the Governors' Conference—a larger participation by the States in the formulation of important national policies.

Always cordially yours,

H. ALEXANDER SMITH,
Chairman, Subcommittee on Health.

JANUARY 23, 1948.

To: Hon. H. Alexander Smith, chairman, Subcommittee on Health, Senate Committee on Labor and Public Welfare.
From: Melvin W. Sneed, professional staff member.
Subject: Summary of reports received from governors in reply to your inquiry of August 7, 1947, relative to consideration of national health policy.

1. State preference relative to S. 545 and S. 1320. To the date of this memorandum reports have been received from 39 of the 48 State governors, many of

whom specifically expressed their appreciation for having the opportunity to indicate their views on matters of national policy. The preferences reported with respect to S. 545 and S. 1320 have been classified and summarized as follows:

Classification:	*Number of Governors*
Favors S. 545 (with or without qualifications)	25
Favors S. 1320	[1] 1
No preference indicated	8
Not in favor of either S. 545 or S. 1320	5
Report not yet submitted	9
Total	48

Identity of the States in the respective classifications is as follows:

Favors S. 545

1. Alabama.
2. Connecticut.
3. Delaware.
4. Georgia.
5. Idaho.
6. Illinois.
7. Indiana.
8. Iowa.
9. Kentucky.
10. Maine.
11. Massachusetts.
12. Michigan.
13. Mississippi.
14. Missouri.
15. Montana.
16. Nebraska.
17. New Hampshire.
18. North Dakota.
19. Ohio.
20. Oregon.
21. Pennsylvania.
22. Vermont.
23. West Virginia.
24. Wisconsin.
25. Wyoming.

Favors S. 1320

1. Utah.[1]

No preference indicated

1. Arizona.
2. Florida.
3. Louisiana.
4. New Mexico.
5. New York.
6. Rhode Island.
7. South Carolina.
8. Washington.

Not in favor of either bill

1. New Jersey.
2. Oklahoma.
3. South Dakota.
4. Tennessee.
5. Virginia.

Report not submitted

1. Arkansas.
2. California.
3. Colorado.
4. Kansas.
5. Maryland.
6. Minnesota.
7. Nevada.
8. North Carolina.
9. Texas.

DEAR GOVERNOR ——————: This is in connection with the letter sent to all Governors by Senator H. Alexander Smith, Republican, New Jersey, concerning the two Federal health measures pending in Congress.

The letter does not give an accurate description of the two measures and appears to be an effort to obtain support for the bill sponsored by Senator Taft and the Republican Party.

Senator Smith has endeavored to give the impression that the Wagner-Murray-Dingle bill, sponsored by the Democrats provides for extensive Federal control over medicine. Actually it provides for local operation of a health insurance plan, assisted by Federal funds, under which patients continue to choose their own doctors as they do now.

On the other hand, the Taft bill would not care for the entire population but only for "paupers." Also, it would give less Federal help to the poorer States which need such help the most.

The Wagner-Murray-Dingle bill proposes one minimum standard of medical care for all the country.

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[1] Subsequently the Governor of Utah indicated by letter to the chairman that an error had been made in the original report to the subcommittee. The Governor requested that the record show that he did not favor S. 1320. The letter from Governor Maw follows the first Utah report.

Senator Smith's letter is carefully written to give the impression that the Wagner-Murray-Dingle bill would encroach upon States' rights.

It would not. What it would do is provide enough funds for all States to do a decent minimum job in medical care for its citizens.

The Taft measure would require needy States to match Federal funds. This would mean that the more a State needs Federal help to provide adequate medical care, the less aid it would be able to receive.

If you are planning to reply to Senator Smith's letter and desire detailed additional information about the two health measures the committee will be glad to supply you with the information.

With best wishes,

GAEL SULLIVAN,
Executive Director.

Must have been written around the first of September 1947:

Do not know if it went only to Democratic Governors or (b) only to Democratic Governors in what might be considered doubtful States.

STATE OF ALABAMA,
DEPARTMENT OF PUBLIC HEALTH,
Montgomery 4, Ala., September 2, 1947.

HON. H. ALEXANDER SMITH,
United States Senator, Princeton, N. J.

DEAR SENATOR SMITH: Your letter to Gov. James E. Folsom, in regard to health bills S. 1320 and S. 545, was referred to the health department. In turn, we have taken the liberty of discussing your letter with the committee on medical care of the Medical Association of the State of Alabama. In your letter you asked several questions, which I would like to attempt to answer.

1. It is impossible to give you any adequate figures as to the percentage of population not getting adequate medical care today. Alabama has always had a small number of physicians to serve its population and this became particularly acute during the war. Since the end of hostilities, however, there has been a marked improvement, since not only have the previous physicians returned but there has been a considerable influx of new physicians. In 1945 there were licensed 84 physicians by examination and reciprocity. This number increased to 179 in 1946, and so far in 1947 we have licensed 129. As of the present there are approximately 2,000 physicians practicing in Alabama.

2. It is not believed that Alabama would approve a compulsory tax plan, as outlined in S. 1320.

3. Alabama very definitely would prefer the S. 545 plan. It is our feeling, however, that each State could administer its own plan and should be permitted to work out a program best suited to its own population.

4. Alabama is divided into 67 counties and we have a full-time health department in each of these 67 units. Many of these units need strengthening but the basic organization is present to supply the public health needs of the whole State.

5. Alabama just completed its survey of existing hospital facilities and has set up a State-wide plan. This plan has been approved by the advisory council and public hearings on it will be held during the month of September, so that it can be submitted to the United States Public Health for approval prior to the first of October. Indications are that there will be a certain amount of building under this program, although the present high cost of building, coupled with the limitation of one-third contribution from the Federal Government is going to make building prohibitive in some of our most needy areas.

I would like to quote from a statement made by the chairman of the committee on medical care of the State medical association:

"During the past 20 years in Alabama our death rate has been reduced more than 33⅓ percent. Many of the old causes of death, such as typhoid fever, diphtheria, malaria, and smallpox, have almost been wiped out. We are now proud of our low death rate and invite comparison with any other State. In another 20 years—with our medical school turning out more good doctors—with our State hospital plan in cooperation with the Hill-Burton law building hospitals in every strategic town in our State—with our voluntary hospital and medical insurance plan available to everyone in our State—with such insurance available to the indigent and medically indigent under the Taft-Ball-Smith-Donnell bill, S. 545—then, we believe adequate medical care will be available to practically every individual in Alabama. Twenty years may seem a long time but, in fact, it will not be long in comparison to the accomplishments."

This office will be pleased to furnish any additional information that may be required.

Thanking you for the opportunity of expressing our convictions, I am

Very sincerely yours,

D. G. GILL, M. D.,
State Health Officer.

Copy to Gov. James E. Folsom

EXECUTIVE OFFICE,
Statehouse, Phoenix, Ariz., November 26, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
United States Senate, Washington, D. C.

MY DEAR SENATOR SMITH: I have your recent letter conveying the information that the Senate Subcommittee on Health is considering Senate bills 1320 and 545, and making inquiry relative to health conditions in Arizona.

As you are aware, these two measures both propose a medical set-up, although through different methods of approach. One would provide medical care as a function of Federal Government and the other would allow the States to participate. Whatever decision is made by Congress as to which method of legislation is most desirable, it is agreed that a solution of the problem of medical and hospital service to persons of moderate means is needed.

This problem exists in Arizona as elsewhere.

On page 2 of your letter, you ask us, in question (1): "How you handle the health problem in your widely scattered rural areas?"

I would answer this question by saying that many of our counties have county hospitals to which patients may be brought for treatment. Our more thickly populated counties have very well developed public-health departments. Most of our schools have school nurses and practically all of our counties have a county physician whose duties vary considerably.

In reply to question (2) "How the new Federal aid to hospitals program is working?" I regret to say that although enabling legislation has been passed by our legislature, no appropriation has as yet been made. I expect to include such an item in my call for a special session of the Arizona Legislature in the near future, and it is my hope that adequate appropriation will be made for financing this program.

If my office may be of further assistance to you and your committee in this, or any other matter, I would be pleased to have you call upon me.

With all good wishes, I am,

Sincerely yours,

SIDNEY P. OSBORN, *Governor.*

STATE OF ARKANSAS,
OFFICE OF THE GOVERNOR,
Little Rock, November 14, 1947.

Hon. H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR SMITH: I have received your letter of November 7 referring to your letter of August 7, a copy of which was enclosed.

Upon receiving your letter of August 7 I referred the matter to the State health department for them to supply you with the information and thought that this had been done.

Of course, it is impossible for me to say just what the legislature might do or what the reaction of the people might be in regard to any proposed tax for the operation of the State health program.

I am referring your letter again to Dr. T. T. Ross, State health officer, and asking him to reply and give you the wanted facts.

Thanking you, I am,

Very sincerely,

BEN LANEY, *Governor.*

AUGUST 21, 1947.

Hon. JAMES L. McCONAUGHY,
Governor of Connecticut.

DEAR GOVERNOR McCONAUGHY: Mr. Belden's memorandum of August 13 with letter from Senator H. Alexander Smith, chairman of the Subcommittee on Health of the United States Senate Committee on Labor and Public Welfare, regarding S. 545 and S. 1320, has been received. Mr. Belden stated that you wished my comments on these bills.

With respect to S. 545, known as the National Health Act of 1947, I enclose a statement of the Association of State and Territorial Health Officers which was prepared from verbal and written comments of many of the State health officers, which may be of interest to you.

In regard to the numbered paragraphs at the top of the second page of Senator Smith's letter:

(1) I do not know of any study that has been made on the details, but the numerous hospitalization plans such as the Connecticut plan for hospital care, and the plans for medical care which the Connecticut State Medical Society is authorized to prepare and which I believe are nearly ready to be put into effect, may answer this question. I am not sure of the exact present status of the State medical society plan, but Creighton Barker, M. D., executive secretary of the Connecticut State Medical Society, may be able to furnish details.

(2) This would seem to be a last resort, if all other plans fail, and perhaps should not be put into effect until we have full-time health services for all the areas of Connecticut which Connecticut is aiding by State financial contribution under the 1947 Public Act 420.

(3) In the statement of the State and Territorial health officers you will see that these State health officers are in favor of S. 545 rather than S. 1320 because of State participation in S. 545. I believe that conditions in Connecticut are such that S. 545 is preferable to S. 1320.

In answer to the numbered questions at the bottom of the second page of Senator Smith's letter:

(1) Health problems in the widely scattered rural areas of Connecticut are handled by the part-time local health officers. In the larger towns, the health officer is assisted by a sanitary inspection for nuisance investigations and food and restaurant sanitation, and sometimes a public health nurse. All local health authorities are assisted in an advisory capacity by the personnel of the State department of health, and when necessary, by active participation of the personnel of the State department of health. Certain services are given directly by the State department of health such as venereal-disease control, narcotic control, maternal-and child-health services, dental hygiene, crippled children services, cancer and other chronic diseases, industrial hygiene, mental hygiene and public health laboratory services. In addition, the supervision of water supplies, water purification plants, sewage disposal plants and sewerage systems is directly the responsibility of the State department of health. Some of this work is done in cooperation with the local authorities, and always with their approval and sponsorship. In addition, all medical problems are greatly assisted by the various advisory committees of the Connecticut State Medical Society which have given unstintingly of their time on many matters pertaining to the health of the people.

(2) The new Federal aid-to-hospitals program is not yet in operation. Public Act 410. An Act concerning hospital and public-health-center survey and construction, was passed by the 1947 Connecticut General Assembly, designating the State Department of Health as the sole agency to administer the hospital and public-health-center survey and construction act authorized unler Public Law 725, Seventy-fifth Congress. The Connecticut-hospital and health-center survey has been completed by this department and the report is waiting the approval of the public-health council of this department and the state advisory council appointed by the Governor before publication and submission to the United States Public Health Service for approval.

Under Public Law 725, Connecticut receives approximately $25,000 for survey purposes for the 5-year period. The Surgeon General of the United States Public Health Service, on application of this department, has authorized the expenditure of the first year's allotment of $5,000. Congress made no appropriation for construction grants, but the Surgeon General is authorized to approve, for construction projects, a sum not exceeding $75,000,000 for the fiscal year 1948, and such approval by the Surgeon General shall constitute a contractual obligation of the Federal Government.

The Connecticut State plan for this purpose has just been completed in tentative form and has not yet been submitted for approval. Thus we do not know how the act will function. However, in the development of the regulations, the United States Public Health Service has demonstrated good cooperation and a desire to interpret broadly Public Law 725 to make it function smoothly.

If there are any further details you wish, please do not hesitate to write me again.

Sincerely yours,

STANLEY H. OSBORN,
Commissioner.

(Enclosures: Senator Smith's letter to Governor McConaughy, copies of S. 545 and S. 1320, extra copy of this letter. Statement of State and Territorial health officers.)

STATE OF DELAWARE, EXECUTIVE DEPARTMENT,
Dover, September 3, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health, United States Senate,
Washington, D. C.

DEAR SENATOR SMITH: I have your letter of August 7 with enclosures wherein you ask for information concerning health and medical problems in the State of Delaware. I submit the following for your consideration:

As far as I have been able to determine, Delaware is perhaps more fortunate than some other States, for it would seem that the population is getting adequate medical care with few exceptions, but it is probably that the so-called white-collar class finds itself unable to pay for all types of medical care in some instances. The rich can pay, and the very poor usually get care for nothing, or very nearly so. In general, it seems that Delaware is not suffering, to put it that way, from inadequate medical care.

It is my belief that S. 1320 has provisions which would be extremely unwelcome and would cause difficulty in this State. Consequently, I do not believe that Delaware should approve favorable congressional action on S. 1320.

S. 545 leaves much to be desired although it is preferable to S. 1320. As I understand it, Delaware has engaged in certain programs with so-called matching money, but these have not always been desirable from this particular standpoint, due to Federal supervision. One could expect that this difficulty would present itself should S. 545 be passed by Congress. However, it should be emphasized, as stated above, that it is preferable to S. 1320 for its features are less objectionable, and there is no earmarked tax in S. 454.

The health problem in our rural areas is usually solved by endeavors of the private practicing physician supplemented with the efforts of the State board of health. Since Delaware has good roads, no large areas to cover, and a reasonable distribution of physicians and hospitals, this problem is relatively simple as compared to some other States. Moreover, the favorable economic status of the rural population, compared to many other States, is quite evident.

The general assembly did not pass legislation which would enable the working of the Federal aid-to-hospitals program; and, as a result, nothing is being done in this connection.

I trust that I have been able to help you in the suggestions made hereinabove. If I can be of further service, I shall be glad if you will so advise me.

Very truly yours,

WALTER W. BACON, *Governor.*

STATE OF FLORIDA,
EXECUTIVE DEPARTMENT,
Tallahassee, August 26, 1947.

Hon. H. ALEXANDER SMITH,
United States Senator,
Chairman, Subcommittee on Health,
Princeton, N. J.

Dear SENATOR SMITH: This is with further reference to your letter of August 7 concerning a national health policy.

I am attaching a statement by Dr. Wilson T. Sowder, State health officer, which I believe suitably answers your questions with regard to the percentage of the population, by classes, that is not being provided with adequate medical care in this State today, and also with regard to the method of handling the health problem in widely scattered rural areas.

The Federal aid-to-hospitals program is not yet in effect in this State. Legislation to activate this service was passed at the recent session of our legislature, and we expect to have the program going by October 1.

Although the survey was sketchy, I gather from the report that Floridans are divided in opinion as to the measures, S. 545 and S. 1320, with some majority in favor of the latter. Florida could operate under either bill but some of the States could not meet the requirements of S. 545. For my own State, I prefer whichever act calls for the least Federal control but you are confronted with a Nation-wide problem and will have to solve it on that basis.

Sincerely,

Millard F. Caldwell, *Governor.*

Statement by Dr. Wilson T. Sowder, State Health Officer

"1. What percentage of the population in this State is not getting adequate medical care today; and what classes—that is, the very poor, the white-collar class, etc?"

Answer: This is a most difficult question to answer and, we believe, impossible. I might say I doubt if anybody in the State knows, with any degree of accuracy, the percentage of the population not getting adequate medical care. On the other hand, most people will admit that there are large numbers of persons, and perhaps a large percentage of the people, not getting such care. There are two principal reasons for this, namely; poverty and a poor distribution of hospital and clinic facilities and physicians. I doubt very much if the poor are getting good medical care anywhere in the State except in the few larger cities where there are clinics and hospitals organized for this purpose. In such large cities, medical care is fairly adequate and is probably better provided for than for persons who have some income but too much to be considered indigent and too little to meet the expenses necessary for doctors and hospitals.

In the rural areas throughout Florida, medical care is not too good for any class because there are few doctors, or none, in the area and few hospitals, or none. It is also true that the better trained physicians, particularly the specialists, are concentrated in the larger towns and cities. This is also true of the better hospitals. The rural population, therefore, suffers not only in the quantity of medical attention they receive but in the quality. The medical care of indigents is also less well provided for in financial terms in the smaller and more rural counties. In some of these areas, the municipalities, or the county, have a part-time physician. Frequently, however, county commissioners pay the bills for indigent persons on a fee basis when the necessity arises. In summary, then, I should say that medical care is inadequate in Florida, in the rural areas for all classes and throughout the State for the low income groups, including the white collar class. If an estimate of the percentage of persons not getting adequate medical care in the State is necessary, my estimate would be around 25 percent.

"2. How do you handle the health problem in your widely scattered rural areas?"

Answer: I have given some indication in answering the first question as to how this is done. It should be emphasized, however, that neither the State Board of Health nor its affiliated county health departments furnish medical care as distinguished from public health and preventive services. There are certain exceptions to this. We do treat all classes of persons with venereal diseases except those choosing to go to any private physician. In areas where we have proper facilities, we diagnose and treat tuberculosis cases by pneumothorax where such out-patient treatment is possible. Ordinarily, however, persons found to have tuberculosis are sent to the State sanatorium if at all possible. Cases of insanity are, of course, referred to the State hospitals for the insane. We are just beginning a program for the diagnosis and treatment of indigent cases of cancer, for which purpose the legislature recently appropriated $200,000. This sum is supplemented by a small Federal grant of about $40,000. Hookworm treatments are given in the areas where hookworm is prevalent but our main effort in connection with this disease is to eradicate it by improving sanitation. Immunizations, prenatal and postnatal care of expectant mothers, and services to children, are furnished. However, the ordinary medical care of sick people has, with the above named exception, not been the responsibility of the health department.

The crippled children's commission does, however, as you know, make provision for crippled children, and since their law was recently amended, for the care of all sick children. However, I understand that their appropriation is inadequate to provide for all the calls made upon them for such services. The council for the blind furnishes medical care to the blind and the State department of education, through its vocational rehabilitation service, provides medical care for adults who can be rehabilitated. Last of all, the welfare board pays for such medical care of indigents as their budget will stand. The primary responsibility, however, in this State seems still to rest with the local authorities and these have provided very little organized medical service in the rural areas. It is my opinion, however, that Florida is not unique in this connection and that the situation here is about typical of most States with a substantial rural population.

I should like also to call attention to the fact that substantial progress is being made in the provision of hospitalization for lower income groups through the Blue Cross and similar hospital insurance schemes. Also the Florida Medical Association has initiated and set up an insurance plan to take care of doctors' bills through a corporation known as the Florida Medical Service Corp. These plans, if extended sufficiently, will help a great deal to solve the problem for low-income groups but whether it will solve the problem satisfactorily or not is hard to say.

STATE OF GEORGIA,
DEPARTMENT OF PUBLIC HEALTH,
Atlanta, September 15, 1947.

HON. H. ALEXANDER SMITH,
United States Senator,
Chairman, Subcommittee on Health,
Princeton, N. J.

DEAR SENATOR SMITH: Reference is made to your recent letter to Gov. M. E. Thompson regarding the attitude of Georgia about S. 1320 and S. 545.

There is a division of sentiment in Georgia, with probably a majority of those expressing an opinion in favor of one or the other being for S. 545. Lack of personnel trained in public health is the principal handicap to a fairly adequate public health program in Georgia.

Medical care in many rural sections is very inadequate, mainly because of lack of physicians and nurses. That will be at least partially overcome when the hospital construction program, as provided for in the Hill-Burton law, gets under way.

Very truly yours,

T. F. ABERCROMBIE, M. D.,
Deputy Director.

STATE OF IDAHO,
OFFICE OF THE GOVERNOR,
Boise, September 17, 1947.

Senator H. ALEXANDER SMITH,
Princeton, N. J.

DEAR SENATOR SMITH: After due study of your letter of August 7, together with S. 1320 and S. 545, the following are my answers to your queries and our reaction to the proposed programs.

With respect to an estimate of the percentage of the population of Idaho not receiving adequate medical care today, it is extremely difficult to make such an estimate. This being a State of vast distances and sparse population, it is not reasonable to expect such facilities are or can be located within what might be termed a reasonable distance. However, the larger portion of our population is concentrated in six trade areas; and according to the latest figures, our physician personnel when compared to total population is above the national average.

Good hospital facilities are available in each of these centers, and such facilities are now planning definite expansion. We have in each of six areas under our public health program efficient health centers engaged especially in preventive effort and in maternal and child health and crippled children's programs. Air transportation, with an expanded state aeronautics program, is making quick transportation from isolated areas to centers much easier of accomplishment. By far, then, the largest part of our population can be served adequately. There are exceptions, of course, but these will be eliminated so far as is possible.

I would say that the majority of our people would prefer—especially if these were the only choices open to them—the plan of S. 545, which leaves to the States policy determining power, as against a federally supervised service such as goes with a compulsory, tax-supported program, as proposed by S. 1320.

In our State those unable to afford adequate medical service are the responsibility of the county of their residence. Performance under this sore of program is of necessity varied—some very good, some very poor. This can, we believe, be met by improvements in our State program.

The department of public health and its advisory council has just completed a State-wide plan for hospital service and is working constantly with the communities needing their aid toward improvement of facilities. As compared to the total need, the amount of financial aid allocated is rather insignificant; but Public Law 725 and the work done by our agencies has stimulated interest, and the thinking and planning resultant therefrom is very heartening.

Trusting that I have properly covered the ground of your queries, I remain,

Very sincerely yours,

C. A. Robins, *Governor.*

Office of the Governor,
Springfield, August 20, 1947.

Hon. H. Alexander Smith,
United States Senator,
Chairman, Subcommittee on Health,
Princeton, N. J.

Dear Senator Smith: Thank you for the opportunity afforded in your letter of August 7 to express an opinion concerning a national health policy. I recognize the tremendous importance of this subject and fully appreciate the difficult task as your subcommittee attempts to formulate sound recommendations regarding S. 545 and S. 1320. I sincerely hope that my answers to your several questions will be of some assistance to you.

"(1) What percentage of the population in the various States is not getting adequate medical care today; and what classes—that is, the very poor, the white collar class, etc.?"

Frankly, a definite answer to this question is not available. As indicated by the enclosed material, I believe that fairly adequate medical care is provided through the Illinois public assistance laws for the very poor who are dependent upon the State or who have low incomes. In many instances this service is supplemented by the work of various charitable organizations. The class which suffers mostly in all probability consists of those with moderate incomes who are not indigent but who cannot afford major medical attention. Undoubtedly many in this group, too, because of financial reasons defer medical or dental service which is not necessarily of an emergency nature but which would be deemed advisable for the sake of increasing physical or mental efficiency and even prolonging life. It would seem to me that the various voluntary health insurance plans, while not perfect, are helping to correct this situation. Actually, however, the percentage in this group which is not receiving the necessary service is really unknown. I am informed that a rather extensive survey would be necessary to determine an up-to-date answer to this question.

"(2) What States would approve a compulsory tax plan such as S. 1320 calls for, with a Government-supervised medical service?" or

"(3) What States would prefer the S. 545 plan leaving to the States the determination of policy—that is, compulsory or voluntary group health plans, etc.?"

The answer to both of these questions may be summarized in this way: Illinois, I believe, would be more in favor of the principle incorporated in S. 545. The provisions of this bill would permit the State to work out its own solution to the problem which may take into account the social, economic and other types of differences between the various areas of the State.

"(4) How you handle the health problem in your widely scattered rural areas."

Illinois has no one official program which provides over-all medical care to people in rural areas. As is the case in most other States, the people rely chiefly on the private practitioners and private hospitals in the local areas. Various voluntary nonprofit plans operate to supplement this system such as the Blue Cross Hospital Plan, the health insurance plan sponsored by the State and local medical societies, etc. In addition, of course, the State government operates directly or gives financial aid to various types of health services which may be outlined briefly as follows:

(*a*) City and county public health departments: On the basis of a subsidy formula, the State provides financial aid to autonomous city and county public health departments. There are 10 city health departments operating on a full-time basis. County health departments have been authorized by permissive legislation only since 1943. At present, twenty-two counties are now or soon will be receiving the benefits of this service. While the programs of these departments are mostly preventive in nature, many of them operate various types of clinics, such as venereal disease, dental, cancer diagnostic, psychiatric, prenatal, child welfare, etc. By and large, the services of these clinics are limited to those who cannot afford medical care or who are referred by private physicians.

(*b*) State district health departments: In areas without full time health departments, the State Department of Public Health maintains district health departments which cover from five to eight counties each. Services are limited essentially to the control of communicable disease. Venereal disease, cancer diagnostic, prenatal and child health clinics are maintained in some of these districts.

(*c*) Medical and dental care provided by Illinois Public Aid Commission: Reference has already been made to medical and dental care for dependent persons made available through our public assistance laws. Such care is provided largely by local physicians and hospitals which are reimbursed by the State. The commission also promotes and aids the conversion of county homes into homes for the chronically ill of which there are now 20 in operation.

(*d*) Department of public welfare: The department of public welfare operates the following institutions which provide medical and allied services to the entire State:

Twelve State mental hospitals,
Illinois Neuropsychiatric Hospital,
Industrial Home for the Blind,
School for the Blind,
School for the Deaf,
Illinois Eye and Ear Infirmary,
Hospital School for Educable Handicapped Children,
Trachoma clinics in various areas of the State.

(*e*) Division of services for crippled children: (a branch of the University of Illinois) provides for the cost of correctional services to applicants throughout the State.

(*f*) Division of vocational rehabilitation (department of registration and education) provides for the cost of medical care for those whose disabilities can be improved or corrected.

(*g*) Illinois Veterans Commission assists veterans in connection with medical attention, vocational rehabilitation and care for nervous and mental disorders.

You can therefore see that a considerable amount of medical service is made available to the entire State even though it is not directed specifically to the rural areas.

"5. How the new Federal aid-to-hospitals is working?"

The Illinois Statewide hospital report and plan has just recently been approved by the Surgeon General of the United States Public Health Service. At the present, application forms for Federal aid are being distributed to over 200 Illinois communities which have manifested an interest in constructing hospital facilities. The recent State legislature not only passed laws which are necessary for Illinois' compliance with the Federal program but in addition appropriated $4,675,000 for aid in local hospital construction which will supplement Federal aid. Up to now I should say that the hospital construction program is working exceedingly well. The response on the part of local communities is most enthusiastic. We anticipate a continued successful operation of the program and believe that it will bring extensive benefits to the people of Illinois, particularly those in the rural areas.

I sincerely hope that the answers to your five questions will prove helpful to you and members of your subcommittee. Thank you again for the opportunity of expressing these opinions.

Yours very truly,

DWIGHT H. GREEN, *Governor.*

State of Indiana,
Office of the Governor,
Indianapolis, September 11, 1947.

Hon. H. Alexander Smith,
United States Senator,
Chairman, Subcommittee on Health,
Princeton, N. J.

Dear Sir: This letter is in reply to your inquiry of August 7, 1947, relative to Senate bills 1320 and 545. I desire to apologize for my long delay in answering your letter, but I desired to secure certain specific data from our State board of health before answering. The five questions asked by you are as follows:

"1. What percentage of the population in the various States is not getting adequate medical care today? and what classes—that is, the very poor, the white-collar class, etc.?

"2. What States would approve a compulsory tax plan such as S. 1320 calls for, with a Government-supervised medical service?

"3. What States would prefer the S. 545 plan leaving to the States the determination of policy—that is, compulsory or voluntary group health plans, etc.?

"4. How you handle the health problem in your widely scattered rural areas?

"5. How the new Federal aid-to-hospitals program is working?"

It is extremely difficult to answer these questions categorically. If they were direct questions requiring a "yes" or a "no" answer, for No. 1, we could say that there is a percent of the population which does not get adequate medical care today. However, this involves a number of conditions which could be met by the State and will be met as our present trend of progress develops. For instance, there are counties in the State where less than 25 percent of the births occur in hospitals, although in other areas, the percentage of births occurring in hospitals approaches 100 percent. Present plans contemplate increasing hospital facilities in needy areas. In addition to this, medical and hospital care is dependent upon the availability of professional persons; therefore, the adequacy of the medical care is not always a matter of economic need, but one of proper distribution of physicians, dentists, and nurses.

1. As regards the need among classes of our people, no department at present is in a position to give statistically sound information. The United States Department of Labor, in 1941, published the facts that 65 percent of families had an annual income below $2,000 and that 95 percent of families had incomes below $5,000. Our State health department is not in a position to judge whether families in any of these categories can or cannot afford adequate medical and hospital care under any given circumstance.

Inquiries were made of our local social agencies and our State department of public welfare, and all sources of information have stated an inability to accurately judge the ability of the various population groups to obtain "adequate medical and hospital care."

2. As regards Senate bill 1320, it is my belief that the magnitude of the program implied by the passage of this bill is not administratively feasible, regardless of any needs of the State or local communities. There are many things in this bill which do not lend themselves to reasonable administration on the Federal, State, and local levels. It seems to me, as it apparently seems to most professional workers, that the proposed program is too complex and too extensive for any need, and it may be beyond the resources of available agencies and personnel.

3. As regards Senate bill 545, it is my understanding that most groups in this State, medical and social, approve of the general intent of the plan. It is felt, however, that exceptions must be taken to some of the detailed stipulations of the bill. This bill would create a national health agency without Cabinet rank. A Cabinet Department of Health, Education, and Welfare appears most desirable.

Under title I, section 104 (a), the bill would establish an agency with unbalanced and fragmented authority. The activities of the existing health agencies should be preserved, but they should be brought together under the direction of a single executive head, preferably with Cabinet status. The person in charge should have reasonable leeway in the determination of the organizational structure of the national health services.

Instead of consolidating most Federal health services under one administrative head, this bill would further fragment such services. The Public Health Service would become merely one of seven or more units; and functions, which it now efficiently performs, would be broken off into autonomous units. State health authorities are now confronted with conflicting philosophies and regulations of the Public Health Service and the Children's Bureau, as well as duplication of professional consultants in medicine, dentistry, nursing, nutrition, and auditing. The Federal Government might well emulate the example of most States by having one department of health, with resulting increase in efficiency and economy. I am informed that State health officers have recommended for years the inclusion of the Children's Bureau in the Public Health Service.

It is noted that on the National Medical Care Council only three of the nine members represent consumer interest. A large representation of this group appears desirable.

The legal requirements for advisory councils and committees, as stated in these bills, would not aid any agency in maintaining administrative efficiency, and this statement applies to both Senate bill 1320 and Senate bill 545. Advisory councils and committees may be helpful, but the selection of such committees or councils should be made to meet a need and should be in accordance with the requirements as determined by the executive or director responsible for administration of the program.

The failure of Senate bill 545 to provide for Federal or State standards referable to methods of administration or quality of care might permit inefficient administration by unqualified personnel.

It appears that in the definitions of organizational structure there are certain inconsistent requisites. For example, under title I, section 104, part (c), it should be noted that the Director of the Office of Medical and Hospital Care Services is required to have 5 years of experience, whereas the Director of the Office of Dental Care Services is required to have 10 years of experience. This inconsistency is not understandable and the requirements of experience do not include any consideration for administrative ability or experience in the field of public health or social administration.

Title VII, part (a), of Senate bill 545 pertains to a survey of the medical needs of our people. This provision seems quite necessary, but the amount of funds assigned to this item would hardly seem adequate since the magnitude of the survey outlined is as great as any health-service survey that has ever been contemplated or placed in operation.

Exception could be taken, also, to a clause in title VII (b), section 712, No. 4, "such programs shall provide for the collection of proper charges of less than the total cost of such services from persons unable to pay in whole, but able to pay in part, therefor." At a glance this might seem like a minor objection, but from past administrative experience, this has proven to be a very important condition. If the clause is to remain at all, the words "of less than the total cost" should be changed to read "of not less than the total cost." As a matter of fact, it is believed that methods of payment should be left to the State agency responsible for the administration of any program, with the requirement that some system of uniformity be established in keeping with the quality and type of the service rendered. Experience has shown that it is absolutely impossible for any individual at a remote distance to determine the value of services in a given rural area and to prescribe a method of payment. Some reliance should be placed upon the administrative ability and judgment of executive directors at the State and local levels.

4 and 5. The answers to these two questions overlap to a certain extent. The problems with reference to rural areas are those of providing public-health services, hospital beds, and more physicians, dentists, and other professional personnel. It is believed that the provision of better medical-care services to the rural groups will be stimulated greatly by the construction of hospitals and health centers. These will attract young physicians, particularly since they will have available, in such hospitals and health centers, the facilities to practice the type of medicine that they have learned in medical schools and hospital internships. It will mean, too, that rural people will not have to travel 30 to 50 miles in order to secure hospital care.

The Federal Hospital and Health Center Construction Act will aid tremendously in stimulating the development of small rural hospitals and health centers. Information secured by the Indiana State Board of Health indicates that 26 communities plan to build new hospitals and 42 will add to existing facilities—using funds made available under the Hill-Burton Hospital Construction Act to aid them in financing such construction.

Two points in this Federal legislation that have appealed to the people in Indiana are (1) that such construction must follow a demonstrated need, following an exhaustive survey and a definite hospital plan, and (2) that the relationship of Federal-State and State-local is much more desirable than previous Federal works programs where the relationship has been direct from the Federal level to the local level.

I believe you might be interested, too, in knowing that through the initiation and stimulation of rural health committees of the State Medical Association and the Indiana Farm Bureau, working with the Extension Service at Purdue University, there is being developed throughout the State rural health committees in each of the counties. Such rural health committees are making an inventory of their own health problems and then formulating plans to meet such demonstrated needs. This, we believe, follows the accepted principle of local community accepting the responsibility for taking care of its own problems, with some consultation from State-wide groups.

The last Indiana General Assembly passed permissive legislation which establishes the legal machinery by which counties or cities and counties may combine to establish full-time local health departments for the purpose of providing public health services throughout the State. This was a forward step in our State since the provision of full-time local health departments, under local direction, is necessary if we are to make available to all the citizens the scientific knowledge for the prevention of disease and the prolongation of life.

In concluding, let me state that these questions are not readily answerable. Within the State itself, there are differences of opinion regarding the adequacy of medical and hospital services and as to whether there is a need for financial assistance from the Federal Government in providing direct medical and hospital services. There probably is a need for some type of assistance in certain areas of this, or any, State. Nevertheless, and I can say this without reservation, everyone in a position of administrative responsibility feels that any health measure of the Federal Government providing assistance to States should leave a considerable amount of administrative judgment and the detailed planning in the hands of the State government and its administrative personnel. Without these rights, we will depart from the basic principles of the Constitution of the United States.

I appreciate your thoughtful consideration in requesting my comments upon these matters. This conforms to the position taken at the Governors' conference in permitting States to have a larger participation in the development of important national policies.

Sincerely yours,

Ralph F. Gates, *Governor.*

State of Iowa,
Office of the Governor,
Des Moines, December 8, 1947.

Mr. H. Alexander Smith,
Senate Office Building, Washington, D. C.

Dear Mr. Smith: If I am called upon to testify before the Senate committee I shall be glad to express my views with reference to a wider National health program.

For your information, however, I am enclosing a copy of a letter from Dr. Walter L. Bierring, which I think will give you in general the picture in Iowa.

Very truly yours,

Robert D. Blue, *Governor.*

[Copy of letter]

State Department of Health,
Des Moines, September 3, 1947.

Memorandum

To: Robert D. Blue, Governor.
From: Walter L. Bierring, M. D., Commissioner.
Subject: S. 1320 and S. 545. Letter August 7, 1947, H. Alexander Smith, United States Senate.

S. 1320 as introduced in the Eightieth Congress does not depart fundamentally from its predecessor, S. 1606 of the Seventy-ninth Congress, generally known as the Wagner-Murray-Dingell bill.

In the new bill a certain amount of decentralization is proposed but it still permits very little local administrative responsibility. This bill is based on the principle of compulsory health insurance, and contemplates a Nation-wide tax on all workers and employers in which the Federal Government assumes responsibility for the over-all medical care of all the people.

It is a definite plan to nationalize medical service, a compulsory medical-care program, and is based on taxation rather than the principle of insurance.

S. 545, the Taft-Smith-Ball-Donnell national health bill, is a revision of the bill sponsored in the Seventy-ninth Congress by Senators Taft, Ball, and Smith and introduced in the Eightieth Congress February 10, 1947, with Senator Donnell, of Missouri, as an additional Member.

This bill has met with considerable approval and support from organized medicine, and appears to offer the best framework on which to build the kind of health legislation that the country needs. It provides for a National Health Agency under medical direction; it provides for assembling health activities of the Federal Government in a single agency, and it recognizes the principle of local responsibility and local control. It is patterned somewhat after the Hill-Burton Hospital Survey and Construction Act (Public Law 725) and one of its best features is the provision that contemplates State surveys to determine need before allocation of funds.

PART A. MEDICAL-CARE SURVEY

The apparent purpose of the part A of the proposed act is to authorize an appropriation of $3,000,000 (Iowa allotment estimate, $52,600) to assist States in making a State-wide inventory of existing medical, hospital, and surgical care, preparatory to the formulation of a plan for extending such care as contemplated in part B, Medical Care Services.

This should be amended to include a State-wide survey of existing facilities for general disease prevention and the maintenance of public health.

It should be recognized that such services as maternal and child health, school-health services, the control of communicable diseases, public-health sanitation, industrial hygiene, special provision for tuberculosis, venereal diseases, cancer and chronic diseases, laboratory diagnosis, nutrition, dental hygiene, health education, vital statistics, medical social work, and other accepted functions of public-health agencies, are a means of preserving the health of a State and the Nation. Without these services, a medical-care program cannot be efficiently or economically administered. After all preventive measures, which are possible in the light of present knowledge, have been applied, there will be an inevitable residual of sickness. It is for the provision of medical and hospital care of these ill persons that a medical-care program is needed.

The American Academy of Pediatrics has just completed a 2-year Nation-wide survey of existing facilities in every State, for the medical care of children. These collected data will promote planning on a local level and serve as a pattern for a more extended survey of facilities for general medical care.

PART B. MEDICAL-CARE SERVICES

Part B will authorize an appropriation of $200,000,000 for each of five fiscal years to assist the States in providing general health, hospital, and medical services for families and individuals with low income (Iowa's annual allotment estimated $3,514,200). During and after this 5-year period, the Congress will review the program and determine the amount to be authorized hereafter.

"The financial contribution made by the State and its governmental subdivisions, must be at least equal to the amount contributed for similar purposes in the year 1946 and at least equal to the Federal aid made available to the State under this legislation."

This bill evidently assumes that the indigent sick will be cared for locally in some form or other. The Iowa medical and surgical care is provided through the university hospital, county hospitals, and other local medical-care systems.

The limitation to "families and individuals with low income" will make it difficult for any State to expand this program to include other segments of the population, should it desire to do so.

If a single medical-care program could be developed, it would be more efficient and economical and be more receptive to the general public and of infinitely greater service.

In Iowa it is difficult to define "low income". There is a decided difference among economists, medical, public health and other authorities, as to what constitutes a low income. Lack of provision of medical care is also not limited in any way to the lowest income group.

The use of the term "low income" presents the aspect of charity, and the means test. As Americans we believe in the dignity and self-respect of the individual and the integrity of the family. For these reasons, the State, rather than the Federal Government, should determine whether or not a medical-care program should be made available to all the people or a certain portion of them.

Any plan should permit a flexibility so that it can be changed from time to time to meet the requirements of the population.

In its present form the bill does not make any provision for supplementary laboratory diagnostic or nursing services, or the prescribed medicines and appliances, which are necessary if an adequate medical-care program of high quality is to be rendered. An amendment providing such additional services is to be recommended.

The increasing development of voluntary pre-payment plans, particularly for hospital care such as the Blue Cross and similar organizations should be carefully considered in planning medical care on a national basis.

The bill also provides for assisting States in making dental surveys, relating to State programs for extending dental care services. The dental survey should be integrated with an over-all survey of public-health and medical-care facilities in the State intended to maintain or improve the health and take care of the sick.

There is great need in this State for the extension of preventive dental care services. All school children need some form of preventive dental care each year, and this certainly should be available to all those who cannot obtain such services.

The present bill contains a new provision authorizing an annual appropriation of $10,000,000 (Iowa allotment estimated $175,000), to enable the Surgeon General of the Public Health Service to develop more effective measures for the prevention and control of cancer, and to assist through grants to States, counties, health districts, and other political subdivisions of the States, in establishing and maintaining adequate measures for the prevention and control of cancer. This provision of the proposed act is to be strongly recommended.

The administrative control is similar to that of the Hospital Survey and Construction Act. A National Medical Care Advisory Council is to be appointed and a similar council in each State.

This bill is a distinct improvement on any national health and medical care legislation previously considered, and the principles involved can be strongly endorsed, although certain changes or amendments should be made to make it entirely acceptable in this State.

In the light of existing conditions in this State, it would be more, practicable to limit Federal legislation for the present to authorizing a State-wide survey or inventory of public health facilities for the prevention of illness, as well as hospital, medical, surgical, and dental care facilities, before a definite medical and dental-care program is inaugurated.

In answer to specific questions asked by Senator Smith, the following is submitted:

"1. What percentage of the population in the various States is not getting adequate medical care today; and what classes that is, the very poor, the white-collar class, etc.."

This is a difficult question to answer concretely for this State.

It is doubtful if any one knows the extent to which medical care is not available to any particular group because of an inability to finance it. It will take a very careful survey to determine this with any degree of accuracy.

"2. What States would approve a compulsory tax plan such as S. 1320 calls for, with a Government supervised medical service?"

The general impression is that this bill is generally opposed in Iowa, and that compulsory health insurance is not the solution for present conditions. At the Senate Hearings last spring representatives of the two National Labor organizations endorsed S. 1320. Thus far there has been no official statement from the two Iowa affiliates of the AFL and the CIO.

"3. What States would prefer the S. 545 plan leaving to the States the determination of policy—this is, compulsory or voluntary group health plans, etc.?"

There has been a general expression from medical, nursing, public health and welfare organizations in preference for S. 545 as best suited to meet health legislation needs at this time.

Two further questions are asked in Senator Smith's letter:

"1. How do you handle the health problem in your widely scattered rural areas?"

The State has been divided into 10 district health services. In each health district there is a medical director, supervising public-health nurse, public-health engineer, with clerical assistants. Each district covers an average area of nine counties, with a population of 200,000 to 250,000.

The budget of this district personnel is provided from Federal funds—general health, United States Public Health Service, and Children's Bureau, Social Security Agency. In 56 counties full-time public-health-nursing services have been established. The salary and other expenses of each public-health nurse are paid equally from Federal funds and local board of supervisors appropriations.

As qualified personnel and additional funds become available, the public-health nursing service will be extended to the remaining 44 counties. At the present time about 60 percent of Iowa communities have the benefit of full-time local public-health services.

It is contemplated in the near future to divide the State into 27 local public-health units or district services. Seven of these units will comprise city and county health departments, and 20 units multi-county health districts.

"2. How the new federal aid to hospitals program is working?"

The hospital survey and construction program in Iowa had an early start, because of the appointment by Governor Blue of a State hospital survey committee on February 15, 1945.

The fifty-second general assembly passed the Iowa Hospital Survey and Construction Act, which authorized an inventory of existing hospitals, surveying the need for construction of hospitals and developing a program of hospital construction of public and other nonprofit hospitals as provided in the act. This will enable cooperation with Public Law 725, Hospital Survey, and Construction Act, Seventy-ninth Congress. The Governor is authorized to appoint a State hospital advisory council consisting of 12 members. A legislative appropriation of $20,000 annually for the biennium was made to match the Federal grant.

The fifty-second general assembly also enacted a Hospital Licensing Act.

An inventory of existing hospital facilities in Iowa has been completed. The plan for hospital construction based on the needs of the different communities is ready to be transmitted to the Surgeon General of the United States Public Health Service.

Local funds are available by subscription or local county bond issues.

As soon as the Iowa plan is approved by the Surgeon General, United States Public Health Service, applications will be forwarded in order of priority and to the extent of the allotment granted to Iowa for the fiscal year ending June 30, 1948. An estimate of needed hospital construction in this State greatly exceeds the grants provided for the 5-year period through the Hospital Survey and Construction Act, Public Law 725.

The establishment of an integrated hospital system as contemplated will distinctly influence the character of medical and surgical service available in the future. It will likewise attract more qualified physicians in the smaller communities than ever before. Both of these factors will have a significant effect on medical care programs to be developed.

COMMONWEALTH OF KENTUCKY,
OFFICE OF THE GOVERNOR,
Frankfort, September 2, 1947.

HON. H. ALEXANDER SMITH,
United States Senator,
Chairman, Subcommittee on Health,
Committee on Labor and Public Welfare,
Princeton, N. J.

DEAR SENATOR SMITH: Upon receipt of your letter of August 7, I transmitted a copy to State Health Commissioner Dr. P. E. Blackerby, with a request that he undertake to assemble informational material on the questions you raised. Dr. Blackerby has supplied me with the following data, which I feel confident is reliable.

In the matter of handling public health problems in Kentucky, this State has pioneered in the development of full-time county health departments. The total number of counties in this State is 120, of which 104 have been organized and intensive programs for health protection developed over the years. Others of the 16 remaining counties are ready for organization and operation as soon as trained personnel may become available. The lack of trained professional personnel constitutes our greatest handicap at this time. There is a serious shortage of both medical and nursing workers. The situation is not so serious insofar as sanitation and other types of personnel is concerned, and at the present time, with the general supervision of part-time health officers in many of our counties, the health program in the main is going along satisfactorily. We do believe that we are sufficiently well organized for the development of any program related to the health services. There is very good correlation of the services of the State department of health, the State welfare department, and the State department of education in all activities directed toward the protection of the public health in the State.

There are two maternity hospitals and health centers in the mountain section of the State and these are contributing a fine service to a considerable population that does not have an adequate supply of physicians and where untrained midwives have in the past given the major amount of delivery service. These centers provide an excellent prenatal care program, together with planned educational activities in the field of child nutrition.

The State department of health maintains three types of mobile units; three traveling clinics for dental services, two traveling clinics for chest X-ray work, as a contribution to the program of tuberculosis prevention. In this particular field the State has one tuberculosis hospital now in operation, and five other such hospitals under construction. There is a large tuberculosis hospital for Louisville and Jefferson County maintained by the governments of same. Lexington and Fayette County also maintain and operate a tuberculosis hospital and two other counties in the State have small tuberculosis hospitals, all of which indicates that the tuberculosis problem will in the near future be met fairly adequately. Through an integrated program of the State department of health and the Kentucky Division of the American Cancer Society, a mobile unit for cancer education and diagnosis has been put into operation. Here again these two agencies are assisting in the operation of 16 diagnostic and treatment centers for cancer control.

The crippled children's commission, operating technically under the State department of health has an excellent program for the detection and treatment of crippled children—the commission carrying the correctional program, and the State health department through its division of epidemiology providing educational and preventive services in relation to poliomyelitis. The full-time county health departments contribute greatly in case-finding of poliomyelitis in the early stages and prompt referral to the crippled children's commission for care and treatment. Many voluntary civic and professional groups cooperate in providing corrective devices, such as glasses for eye defects, braces, etc., and in the sponsoring of health education programs. As an illustration of health education sponsorship, the Kentucky Federation of Women's Clubs and the Congress of Parents and Teachers jointly sponsored a series of health institutes, one for each federation district and practically without exception each attracted large attendance.

The State health department has a division of industrial hygiene with a splendidly equipped laboratory, and this unit provides consultative and advisory services to many of the industries in the State, and sentiment is gradually being built up in regard to the value of such a program.

A program is now being developed whereby mental hygiene services, both educational and clinical, will be made available to the State and this program will be pushed as rapidly as personnel and facilities become available.

Each county health department in the State maintains a venereal disease clinic where individuals may report for the various tests for the detection of venereal diseases, and adequate treatement for these diseases is provided for the medically indigent. With the cooperation of the United States Public Health Service there are maintained two rapid–treatment hospitals for the care and treatment of early, secondary, and early latent cases of syphilis. The bed capacity is something over 200 and these are practically filled to capacity at all times, with an average treatment stay of 11 days.

The State health department publishes a monthly health bulletin, with a wide distribution in the State, and in addition makes available many types of health literature for libraries, schools and general consumption.

The Governor of Kentucky, under authority of law, recently created within the State health department a division of medical, hospital, and related services, and the State health department reports this division's activities as follows:

The division of medical, hospital, and related services completed in 1946 a State-wide survey of existing hospital facilities, and in connection therewith made an intensive study of hospital needs, with a view of putting into operation as early as possible a program for utilizing Federal aid as provided in Public Law No. 725. The division has just completed its State-wide plan for a hospital construction program and submitted the plan to the Surgeon General of the Public Health Service for approval, which will be forthcoming shortly. Under this plan priorities are set up for communities on the basis of the greatest need, taking into consideration first those areas where hospital facilities are nonavailable within a radius of 20 miles or more, then following the priorities on the basis of needs met. Formulas for developing these priorities were worked out in agreement with representatives of the Public Health Service. The Governor has appointed an advisory council to the State health department to assist in the development of a plan and the putting of it into operation. On this council and the medical profession, hospital administration, agriculture, labor, architects, and the consuming public are all represented. The membership of this council is not only representative but interested, and actively cooperating with the State health department

The greatest handicap to hospital construction in many areas of the State is the economic situation, and in many of the areas of greatest need the per capita wealth is so low that having to provide two-thirds of the cost of construction will in too many instances prove a complete barrier. It is our judgment that the formula for grants-in-aid for communities on the basis of per capita wealth and resources as first proposed in the United States Senate would have served to much greater advantage in the rural areas than that which is provided in Public Law No. 725 as finally enacted. The only solution to this situation may be through appropriation by our State legislature, if such can be done under our present constitution, which thing is now in doubt. A number of counties which, under our fiscal system are legally able to float bond issues have done so, which gives assurance of new construction or additions to existing hospitals where needs are demonstrated. It follows, therefore, that the advantages of Public Law No. 725 will be utilized and bed facilities greatly increased in the State, but, still leaving many other sections with equal or greater needs struggling to find financial resources for hospital construction and maintenance programs.

The State maintains 2 public service laboratories for diagnostic services to the medical profession and the people, and 10 county health departments have reasonably adequate laboratory facilities, with trained technicians. In addition, there are approximately 100 private laboratories in the State, all of which contribute in maintaining reasonably adequate laboratory facilities for all the people.

The State health department maintains a tabulating unit for various types of health programs, and in connection therewith maintains an up-to-date register in relation to the per capita distribution of physicians, age distribution, specialties, etc.

As of August 1, 1947, the total number of physicians in active practice in Kentucky was 2,320; the ratio of doctors to population for the entire State is 1 to 1,226; the average ratio of doctors in counties with cities of the first and second class is 1 to 678; the average ratio of doctors to population in counties with cities of 10,000 or more, not including first- and second-class cities, 1 to 1,050; the average ratio of doctors to population in all counties with cities under 10,000 is 1 to 1,871.

There are 32 counties in the State that represent a need for one or more physicians at this time, and attention may be called to the fact that beyond this immediate need there are a number of anticipated needs growing out of the age distribution of physicians. In these latter years of age, and here the practice expectancy cannot correspond to the life expectancy.

Provision for hospital and medical care for the indigent and medically indigent varies in accordance with the resources of the various fiscal agencies of the State. Practically all of the urban centers and many of the wealthier agricultural centers provide a reasonably adequate service, but there are a large number of counties where there is only a very limited medical-care program provided. Thus it will be seen that it is the lower income and indigent groups that suffer for lack of medical care in many sections. There are five voluntary hospital-insurance plans operating in the State, with a total coverage approximating 300,000, and here the so-called white-collar classes find opportunity for protection in the matter of securing hospitalization. The State farm bureau and many other organizations and industries are urging their members and employees to participate in the hospital-insurance program which bids fair to a reasonably rapid growth in this field. The State legislature has provided an enabling act for a voluntary insurance medical-care plan, and arrangements are now being made for the organization and development of such a program under the sponsorship of the Kentucky State Medical Association.

Labor organizations are, as a rule, in support of proposed legislation by Congress for a compulsory system of insurance for hospital and medical care, but a careful study of the sentiment in the State by the Kentucky State Medical Association indicates that most of the people would prefer a system of voluntary insurance in these fields, with provision by the Federal and State Governments for grants-in-aid to supply the care of the indigent and medically indigent. There is a widespread interest favorable to the rapid development of hospital construction as provided under Public Law No. 725, and if these hospital units become available grants-in-aid for hospital and medical care for the indigent and low-income groups would result in not only a better distribution of doctors, but a far more adequate medical- and hospital-care program for all the people. The agencies administering grants-in-aid could provide directly for the low-income groups, or contract with the hospital plans.

We view with some alarm the tendency on the part of some organized groups in this country toward fostering nationalistic programs and believe there is a more formidable group insistent on maintaining in this country the freedom of individual and collective action for all enterprises serving the people. Certainly England is demonstrating at this time that nationalistic programs become accumulative and tend to jeopardize the national economy.

We should like to submit, therefore, that it is right and proper for the Federal Government to provide grants-in-aid to States to assist in meeting demonstrated human needs, at the same time allowing for State determination of programs.

Trusting the foregoing will be most helpful to you, I am,

Sincerely yours,

SIMEON WILLIS, *Governor.*

STATE OF LOUISIANA,
OFFICE OF THE GOVERNOR,
Baton Rouge, September —, 1947.

Hon. H. ALEXANDER SMITH,
United States Senator, Chairman, Subcommittee on Health of the Committee on Labor and Public Welfare, Princeton, N. J.

DEAR SENATOR: In reply to your letter of August 7, relative to Senate bills Nos. 545 and 1320, you are advised that I submitted copies of your letter to the State health officer of this State for reply to certain of your questions, both numbered (1) and (2) lists of questions contained in your letter. I am enclosing your copy of the letter from our State health officer in answer to the two questions referred to.

As to how the Federal aid to hospitals program is working, you are advised that we have completed the survey required under the provisions of your Law 725. We are now in the planning phase of this program, and our plans should be completed within the next 2 months. We will then be ready to enter the construction phase of the program.

I am unable to give you any answer to questions Nos. 2 and 3, as to whether the State of Louisiana would approve a compulsory tax plan such as S. 1320 calls for with a Government-supervised medical service, or whether this State would prefer the plan provided for in S. 545, leaving to the State the determination of policy—that is, compulsory or voluntary group health plans, etc.

We feel that our two Senators are capable of determining what is best for our State on any Senate bill of the nature of S. 545 and S. 1320.

I am sending Senators John H. Overton and Allen J. Ellender of Louisiana a copy of your letter and this reply.

Yours very truly,

J. H. DAVIS, *Governor.*

State of Maine,
Office of the Governor,
Augusta, November 21, 1947.

Hon. H. Alexander Smith,
Chairman, Subcommittee on Health,
Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

Dear Senator Smith: I must first apologize to you for the delay in replying to your letter of August 7, 1947, in which you refer to two proposals; namely, S. 1320 and S. 545, in connection with public health in this country. I referred your letter to the State department of health and welfare, atttention of Mr. David H. Stevens, commissioner of that department, and, due to the fact that we have been going through a period of rather extensive changes in the administration of welfare laws in our State, material was not forthcoming from that department which was needed in order to make a reply to your letter. However, I am now advised that the following would be the situation in so far as Maine is concerned:

1. Any estimate on percentage of population getting adequate medical care would be based on factors which are not at all well known; such as, for instance, the extent of poverty, geographical isolation, and isolation by weather, ignorance of existing facilities, and other unusual conditions. The department of health and welfare does estimate, very roughly, that perhaps 20 percent might be a fair figure for those not receiving adequate medical care, and for those not getting ideal medical care the figure, of course, would be much higher.

2. The idea of a compulsory tax plan to finance a rather all-inclusive health program, such as outlined in S. 1320, is one that would probably meet with considerable opposition in Maine. We have a record for being extremely conservative in tax matters as evidenced by the fact that at the present time we do not have any general sales or income taxes. If, therefore, the people of this State should have an opportunity to vote on such a measure (which they presumably might not have if it were enacted by the Congress), I doubt very much if such a plan would meet with approval even though it were tied in with extensive public health and preventive medicine proposals.

3. I do not believe that I would care to state without any qualifications or equivocations what the State of Maine would prefer in the matter of S. 545 v. S. 1320 when one takes into consideration all of the phases of public health which are involved in these two bills. As I stated above, the idea of a compulsory tax, contained in S. 1320, would not be acceptable to Maine. On the other hand, the provision in S. 545 for removing the Children's Bureau and the United States Public Health Service from the Federal Security Agency, where these two units are located, seems to be rather unnecessary and certainly is in conflict with the idea expressed by Senator Taft in the Taft-Fulbright bill which, I believe, provides for Cabinet status for health, welfare, and I think education. It seems to me there are many weaknesses in S. 545 which, presumably, may be corrected in some re-draft. ,Is it not true that Senator Taft is at the present time re-drafting his bill with the thought of removing some of the objections which have been expressed both at the public hearings and subsequently by those studying this matter? While I have every sympathy in the world for those in the medical profession, it does not seem to me that it is necessary to disrupt the organization of the Federal Government in order to set this function apart as an independent agency when there are, no doubt, other functions in Government, such as perhaps welfare, which are equally important. I do believe that the principal of grants-in-aid, as enumerated in S. 545 would be more acceptable to the State of Maine than an over-all pay-roll tax. On the other hand, our State, which is economically not rich, would have some difficulty in finding the necessary funds for administration and for the supplying of necessary medical and dental services which are provided for in S. 545.

4. I have been advised by our department of health and welfare that every effort is now being made to bring about a proper appreciation in the rural areas of our State that public health and preventive medicine is something which is the responsibility of not only the State but the local municipalities. The department of health and welfare sponsors rather successfully, with the cooperation of the doctors, clinics of various kinds and types in these areas. The State has nearly 50 public health nurses on the State pay roll and there are about 85 other public health nurses employed by municipalities and private agencies who have been most active in promoting these clinics. We have a mobile X-ray unit which is used in connection with tuberculosis prevention work. We have one dental

trailer (and would like another) which is used exclusively in rural areas. While we are, as in most States, scarcely scratching the surface of this problem, nevertheless we are making progress.

5. The Hill-Burton law in regard to Federal aid to hospitals has not produced any tangible results in the State of Maine as yet due to the fact that we are now in the final stages of preparing the over-all State plan for submission to the public and then to the United States Public Health Service. It is expected that real benefits will accrue from this law when our program is set up and has progressed to the point where Federal funds can be obtained.

I hope this rather long and somewhat rambling letter will give you some idea as to our thoughts in Maine in regard to this most important problem.

Sincerely yours,

HORACE HILDRETH, *Governor.*

THE COMMONWEALTH OF MASSACHUSETTS,
EXECUTIVE DEPARTMENT,
Statehouse, Boston, December 8, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health, United States Senate,
Washington, D. C.

DEAR SENATOR: The questions which you have asked in reference to Senate bills 545 and 1320 have been carefully considered.

Without a survey it is not possible for me to state accurately the percentage of our population that is not receiving adequate medical care today. The Massachusetts Medical Society is now conducting a survey which will produce this information but, unfortunately, the results are not available at this time.

Massachusetts has been a leader in the field of public health and medical care and we are desirous of seeing these services extended. We do not approve, however, of a compulsory system of socialized medicine. It is our belief that a voluntary system with Government assistance is better adapted to meet the needs of the situation. We, therefore, prefer Senate bill 545 rather than Senate bill 1320.

Public health problems in our rural areas are handled by the State department of public health. It has organized the Commonwealth into eight health districts, which it supervises through its division of local health administration. District health officers in each of the eight districts cooperate with and assist the local health departments in carrying out their functions. The organization is discussed in the Handbook for Physicians published by the department of public health and I am forwarding a copy under separate cover.

In order to obtain the benefits of the new Federal aid to hospitals program, the department of public health has organized a division of hospital survey and construction which has developed a plan of survey of medical facilities in the Commonwealth and is preparing a tentative plan of hospital construction to be submitted to a public hearing this month. On the basis of these plans, Massachusetts will be eligible to receive the Federal funds provided under the law.

I hope that the foregoing comments will be helpful to your committee and regret the delay in answering your letter.

Sincerely yours,

ROBERT F. BRADFORD, *Governor.*

STATE OF MICHIGAN,
OFFICE OF THE GOVERNOR,
Lansing, Mich., November 24, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
United States Senate, Washington, D. C.

MY DEAR SENATOR SMITH: May I first express my appreciation for your having consulted me about this most important problem of health, before answering the questions which you have asked.

Michigan's population has the opportunity of voluntarily selecting their medical care and paying for it. This accounts for the major part of the population.

The indigent and medically indigent have available to them medical care through the county departments of social welfare with the expense shared in part by the State. The county departments of social aid look after the group involving old-age assistance, aid to dependent children, and aid to the blind.

There is provision for veterans having service-incurred illness through a contractual program between the Michigan State Medical Society and the veterans' trust fund. This provides local medical care and hospitalization for such veterans.

There are special medical programs providing for the tuberculous, crippled children, the mentally ill, and those with communicable diseases. These are paid from tax moneys by the county, by the State, or jointly.

This leaves only one uncovered group of population, that of migrant workers who have not gained residence in the State. Even in this group, the Michigan law provides for care of the tuberculous as State-at-large, pending further disposition of the individual case.

So, in answer to your first question, it appears that only about one-half of 1 percent does not have available medical care.

It is my conviction that Michigan would favor the S. 545 plan which leaves the determination of policy to the States. S. 545 embodies many of the factors which I believe are already in operation in Michigan and which closely correlate with the existing health plans. S. 545 also makes provision for the discrepancies still existing in the provision of total medical care in Michigan. We do have extensive voluntary group plans which are growing in coverage of various social economic groups.

Relative to your question about health problems in widely scattered areas, let me say first that Michigan has full time local health department services for 92 percent of its population. Immunization services, well child care, maternal and child health programs and public health nursing services to the school and family along with sanitation services are available to practically all of our population. The acutely ill who is indigent or medically indigent, is provided for through the county social welfare program. Several types of illness, such as tuberculosis, etc., as mentioned above, are handled either through the local health department, probate court, or other local officials. The public health service programs of the local health department are prosecuted in close cooperation with the practicing physicians in their jurisdictions.

With respect to the new Federal aid-to-hospitals program, let me say that this program in Michigan is progressing satisfactorily. As you know, Michigan was the first State to complete its hospital facilities survey. I have appointed a well trained hospital administrator as a part of my executive staff to develop this program. He has his quarters in our State health department to better coordinate the relationship with the district office of the United States Public Health Service.

Again may I thank you for your interest in health services in Michigan. I appreciate the opportunity of giving you this information.

Sincerely,

KIM SIGLER, *Governor.*

STATE OF MISSISSIPPI,
EXECUTIVE DEPARTMENT,
Jackson, November 18, 1947.

Hon H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR SMITH: This is to acknowledge receipt of your letter of November 8, 1947, enclosing copy of your letter dated August 7, 1947.

Insofar as I am concerned, the only health policy that would be agreeable to Mississippi would be S. 545. The other bill mentioned in your letter tends toward centralization of authority and making the States more dependent upon Federal aid rather than performing the service themselves.

I am very glad to say that Mississippi has embarked upon a program of furnishing hospital aid to its rural population and was, in fact the first State to have its program approved by the Federal Government, and this program in effect leaves the matter in the hands and control of local governing bodies.

In view of the above statement, I would be opposed to S. 1320 in its entirety and would, on the other hand, be willing to support S. 545.

Sincerely yours,

F. M. WRIGHT, *Governor.*

STATE OF MISSOURI,
DEPARTMENT OF PUBLIC HEALTH AND WELFARE
September 15, 1945.

HON. H. ALEXANDER SMITH,
United States Senator,
Chairman, Subcommittee on Health, Princeton, N. J.

MY DEAR SENATOR SMITH: Your letter of August 7, 1947, to Governor Donnelly was referred to me for reply inasmuch as your questions call for certain conclusions which, as you indicate, can best be based on information possessed by our division of health in this department.

In answer to your first question, may we say that we have no accurate way of estimating the percentage of population in this State that is not getting adequate medical care to date. It is our belief that in the rural sections, a great many of our poor people are not getting it, but in the larger municipalities and the metropolitan areas, the very poor are able to obtain adequate medical care through the hospital divisions of the city.

Questions Nos. 2 and 3 in your letter may well be answered together. The representative of the State and Territorial health office, Dr. Getting of Massachusetts, presented the opinions of the official State health agency to the committee on both of these bills, namely, S. 1320 and S. 545, and we believe that his testimony is applicable today.

The other question No. 1 toward the end of your letter may well be answered by saying that scarcely any planned long range program of rendering actual care is in effect in the widely scattered rural areas of our State. The furnishing of medical service is in the hands of the local county courts and varies all the way from very good to very poor.

Your question No. 2 in the same series relates to Federal aid to hospitals. The hospital survey program is now in very active operation. The survey is 50 percent completed, and we expect to be in a position to accept project applications for aid not later than January 1, 1948.

Thank you for giving us an opportunity to patricipate in the formulation of important national policies concerning health and welfare.

Very truly yours,

(Signed) S. Marsh,
(Typed) SAMUEL MARSH, *Director*

STATE OF MONTANA,
OFFICE OF THE GOVERNOR,
Helena, November 14, 1947.

HON. H. ALEXANDER SMITH,
United States Senator, Washington, D. C.

DEAR SENATOR SMITH: In answer to your letter of August 7, 1947, the following information is submitted for use by the Subcommittee on Health of the Labor and Public Welfare Committee of the United States Senate in connection with S. 1320 and S. 545.

In any consideration of the health situation in the State of Montana, it is necessary to distinguish between health matters and care of the sick. In Montana, health matters are under the control of the State board of health, which is administered by a secretary. The board supervises such matters as sanitation, quarantine, immunization, food and restaurant inspection, dairy and milk inspection, public-health nursing, and health education.

In connection with the care of the sick, I shall discuss this topic under two headings, the first of which is with reference to those who are able to pay for their care. For this group, we are, in general, well supplied with physicians. There is probably no place in Montana to which doctors cannot be called rapidly in case of emergency, although there are several smaller towns which are without the services of a physician, and some steps may have to be taken to correct this. Unfortunately, in some of the smaller areas, there is not enough medical work to keep a physician busy full time. My conclusion is that in Montana inadequacy of medical service is due largely to unequal distribution and underutilization rather than to a lack of general practitioners and specialists.

The second group is those who are unable to pay for their care. In Montana medical care for this group is carried out under State law by contract between the county commissioners and county physicians. This system leaves much to be desired. In several counties, the law has been circumvented, and other methods have been devised.

Changes in this State law should very materially improve the type of medical service to this group, which includes 4 percent of our population. The percent of "medically indigent" is probably much higher; these are not included in the relief rolls, but are unable to meet present costs of adequate medical care. Inadequacy of what are considered minimal essentials in public health services in local area is our major problem at present.

As far as the general health condition in the State of Montana is concerned, it is excellent. Our per capita death rate and our maternal and child health record are likewise very good.

In connection with the health situation in Montana, I believe it important to mention the part played by the Montana Physicians' Service, acting in cooperation with the Montana Hospital Service Association or Blue Cross plan.

This voluntary, nonprofit, prepaid type of medical care was instituted September 1, 1946, and has shown a rapid growth. Since contracts have been available, approximately 33,000 have been put into effect to date. I might mention that this growth in Montana, as compared to other States, has been very great. For instance, the New Mexico plan began enrollment during May of 1946, and to July 1, 1947, had only 4,085 members, as compared with Montana Physicians' Service which had 27,882 members on that date and had been in effect about 4 months less.

Today the Montana Physicians' Service has 34,000 members; Blue Cross has about 45,000 members. Combined, these approximate about 80,000 or somewhat less than a fifth of the population of Montana. In addition, there has been established a Montana Health Planning Board, which hopes to integrate health activities planning and to correct deficiencies in supplying public health, medical and hospital services to all areas and citizens of Montana within the range of existing laws and health agencies.

As far as Federal aid to hospitalization is concerned, this program is just getting under way in the State of Montana. The 1947 session of the Montana legislature enacted into law a bill providing for an inventory of existing hospitals, for a survey of the need for additional hospital facilities, and for the development and administration of a hospital construction program and providing for compliance with the Federal Hospital Survey and Construction Act. Already, some 20 areas have signified their intention of making application for Federal funds—most of these are rural areas which will require from 10 to 20 bed facilities.

With specific reference to the two bills under discussion (S. 1320 and S. 545), I believe both of them have objectionable features; but of the two, the Taft bill seems less objectionable.

S. 1320 provides for a federally sponsored health program, primarily financed by a Nation-wide pay-roll tax. The bill, as present drawn, takes from the States control over medical and health matters. In my opinion, a decentralized program, retaining primary responsibility in the States, would be superior to a Federal program. S. 1320 establishes a new Federal bureaucracy, for it can be called by no other name, and I question whether a sufficient number of trained personnel could be made available in time to effectuate the program. Another serious objection to the passage of S. 1320 is the almost universal opposition it has received from members of the medical profession. The success of any such program will have to depend on the services of practicing physicians, and their full cooperation is essential.

S. 545 attempts to meet some of these objections. It deals with health as a local problem, and under its provision the States will actually administer the law. However, I seriously question the wisdom of the limitation of the program to "families and individuals with low income," which, to my way of thinking, would limit the effectiveness of the program. Medical care should be made available to the population as a whole, and it should be left to the individual States to determine how extensive the program should be. No restrictive limitation of this nature should be written into the bill. This is a matter for the States, and although the Federal Government's participation is welcomed, that should not amount to the control of the plan.

In connection with S. 545, I respectfully refer you to the testimony already of record submitted by the State and Territorial Health Officers Association. This is a calm, dispassionate analysis of the bill and is an honest endeavor to bring important facts to the attention of your committee.

Very truly yours,

SAM C. FORD, *Governor.*

STATE OF NEBRASKA,
DEPARTMENT OF HEALTH,
Lincoln, December 11, 1947.

Hon. H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR SMITH: With reference to the pending legislation now before the Congress, has been referred to the Nebraska State Department of Health. Will attempt to answer the important questions which enter into the consideration of the bills (S. 1320 and S. 545).

Question 1: It is my opinion that no one in Nebraska but what has adequate medical care today. To define adequate medical care might well provoke an argument from the socialistic "do-gooders." While it is true that every citizen in Nebraska is not financially able to provide the "superdelux" type of medical care that some of the high-powered specialists have been offering, but that does not mean that they're being denied good medical services by their own family physician. I am sure that Nebraska has provided adequate medical and surgical care for the indigents.

It may be true that some of the white-collared class find it a little difficult, from a financial standpoint, but in most instances the medical profession does provide adequate care (and take into consideration ability to pay for such services).

It seems to me that Nebraska's problem has to do with the distribution of physicians. This same situation exists throughout the Middle West. Most of the medical men are located in the more populous centers and leave many areas at some distance from hospitals and medical men. But with our present day transportation facilities, improved highways, they can in a very short time if necessary, reach hospitals and medical services.

It is my opinion that many of the smaller villages, who once had physicians, that it could be that physicians will not locate there in the future. I think this is brought about by the changes in our mode of living, with roads and transportation as we now have them, that there is not the need for medical men to be in each small community. A physician must think of his family, as many of those areas have limited educational facilities for his children and too many times the persons residing in that area only use a physician in emergencies and will drive through his town on to the more populous centers for what they think is a better medical service. So, it is doubtful that we will ever see the time when those small villages have physicians located there.

Question 2: There are only two States, to my knowledge, that are promoting compulsory tax plans for medical care. They are California and Rhode Island. The Governors in those States have been quite active along this line. As a physician, and as a public health officer, I certainly would not favor a compulsory tax plan as S.1320 calls for.

Here in Nebraska the medical profession has taken steps for a voluntary sickness insurance plan and is meeting with considerable success and seems to meet the needs and has approval of the medical profession, which in my opinion should be given a trial before any thought is given to a compulsory tax plan and administered from the Federal level.

Question 3: I believe that all States would prefer, where any plan for tax compulsory medical care plans, if such a law was enacted, should be administered at the State level and determination of need at local levels.

Question 4: (*a*) The method of handling health problems in widely scattered rural areas, every effort is being made for the organization of district health units, with emphasis placed on a preventive program.

(*b*) With the passage of the Hill-Burton bill and with necessary State legislation having been enacted last session of legislature, which I am sure will in the future solve some of the problems, with reference to medical care for isolated areas.

The new Federal aid to hospitals program has progressed only to the point where the survey has been made, and since the law became effective in September 1947, there is little that we can state as to how the program is working. However, we are receiving many requests for information regarding this program and are at the present time setting up the procedure whereby those areas that are interested can make application for Federal grant-in-aid on the hospital construction program. However, it is our opinion that not all of those who have made inquiry or will make formal application will be passed on favorably by the advisory council, for the reason that it may not be feasible to have a medical center or a hospital located in all the areas that might make application.

There is considerable thought being given at the present time to many of the isolated areas. First: Some type of ambulance service so that they could reach medical centers and hospitals. Second: Limited facilities may be considered of small medical centers with a few beds, rather than establishment of a moderate or large hospital, the thought being that the smaller centers with a few beds would answer for most emergencies and that if necessary could be transported at a later date to a larger hospital at a medical center.

In contacting most citizens of the State I am sure that by far the majority do not prefer a compulsory tax insurance medical plan, administered from Federal level.

Respectfully,

W. S. PETTY, M. D., M. P. H.,
Director of Health.

STATE OF NEW HAMPSHIRE,
EXECUTIVE DEPARTMENT,
Concord, October 17, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Senate Subcommittee on Health,
Princeton, N. J.

DEAR SENATOR SMITH: Your recent letter to me concerning Senate bills 1320 and 545 has been received. I appreciate your courtesy in requesting my opinion of the merits of these two bills as they might affect New Hampshire. I shall endeavor to answer these questions you have asked in the same order in which they were presented.

You request information as to the percentage of the population not receiving adequate care and also the type of economic classes not receiving adequate medical care. The percentage of the population not receiving adequate medical care would depend entirely on the "yardstick" used as a measurement for adequate medical care. I may say, however, the so-called white-collar class and the group of persons in a similar moderate-income class is large in this State and has suffered severely financially when unexpected or prolonged illness has occurred in their families. Frequently "nest-eggs" and life-savings were spent to cover diagnosis and expensive medical and hospital treatment. In the "white-collar" group and to a fairly large extent among industrial workers (who in New Hampshire are mostly skilled workers) a large measure of the financial burden involved in prolonged illnesses has been alleviated considerably by voluntary nonprofit group insurances which are popular and have been eagerly sought by large elements of the population. This a group insurance which has not been available to independent workers, farmers, and businessmen.

Recently the Blue Shield, a similar nonprofit group insurance, has provided for payment of medical and surgical attendance. To a less extent, this has alleviated the financial burden of adequate medical care to the "white collar" and industrial workers groups, and as in the case of the hospital insurance, has assured quite adequate medical care to the groups who are members of the insurance plan. The recent inflationary tendencies of prices in general has to an extent reduced the amount of relief afforded by these insurance plans. The economic groups receiving comparatively inadequate medical and unquestionably inadequate dental care are those groups of very low economic status living in rural and urban areas but mostly in rural and semirural areas.

The S. 545 plan to allow the individual States to determine their own policy concerning compulsory voluntary health plans, I believe, would be more acceptable to the people of New Hampshire than the plan as is called for in S. 1320 or nationally supervised medical service. I have been informed by officials of the New Hampshire Medical Society, and the New Hampshire Dental Society, the New Hampshire Osteopathic Society (with suggested reservations for protection of osteopathic physicians) and the New Hampshire Hospital Association, that these societies are strongly of the opinion that a compulsory tax plan such as is called for by S. 1320 would be not only unworkable and disastrous to the healing arts professions, but would result in a widespread reduction in the standards of medical care available to citizens of this State.

The members of these associations are the persons most intimately in touch with the medical problems and they are sure such a bill would lower standards of all the healing arts professions and would not give adequate medical care to the people of this State. I do think that the general population who would be the recipients of either plan are somewhat confused as to which bill would be preferable. There seems to be a consensus of opinion that some type of relief is necessary for the lower income groups if we are to maintain and improve the general standing of health in this State.

Physical examinations conducted by Selective Service in this State disclosed, as they did in all the States in the Union, a regrettable amount of preventable or remedial defects among the youth. It is recognized by all thinking individuals that the youth of any State should not reach maturity with remedial or preventable medical or dental defects. This is essential to the general well-being of the State and country. Without some type of economic aid to help the lower income groups to receive adequate medical and hospital care, this goal cannot be reached. It is my opinion and I believe I would be supported by the general population of the people of this State, that S. 545 would aid in accomplishing this in a far better manner than as outlined in S. 1320. In addition from a governmental standpoint and from the standpoint of well-being of this State, any plan administered and controlled by responsible New Hampshire persons acquainted with the particular problems in our own comparatively small area would be far more efficient and immeasurably more satisfactory to the State than one conceived and administered on a National level. There is probably no one medical care plan that can be successful in all States of the Union with their varied economic, geographic, and social problems.

You request information as to the situation in our State with regard to the following matters:

How we handle the health problems in our widely scattered areas: Compared with most of the large States in the Union, we have no truly scattered rural areas. We do have occasional isolated farms and rather isolated hamlets and towns; however, there is scarcely an area in the State which is more than 25 or 30 miles from a physician and from some type of hospital. So far as can be determined, there are only isolated instances of individuals or families who have difficulty in securing medical attendance or hospitalization by reason of their isolation. The difficulty in securing such attendance and such care is mostly due to inadequate economic resources. The rural isolated area problem involves only a small minority of the population of the State. I have been informed by the secretary of the board of registration in medicine that there is scarcely any area in the State totally uncovered by physicians or hospitals except possibly an occasional isolated lumber camp in which a physician is not available on short notice. There are, however, many rural areas in this State which definitely have inadequate dental care, the population being unable economically to support a dentist. Therefore, we find in certain areas that prophylaxis and dental care are regrettably inadequate. There are, of course, in some of our cities elements of our population which, because of their low economic status, are unable to secure adequate medical or dental care also. These are people who because of economic or other reasons have not been able to obtain voluntary health and medical and hospital care group-insurance. There is at the present time no voluntary dental insurance comparative to the Blue Shield and Blue Cross.

The new Federal aid to hospitals should in time ease to an appreciable extent the problem of inadequate hospital facilities. We have almost enough hospitals strategically located in the State, but they are not all adequately equipped to care for the medical problems in their areas. It is too early to state just how much Federal aid will alleviate this situation. I, personally, deplore the modern tendency of Federal intervention in the internal affairs of our State. I believe this tendency is inimical to the best interests of our democratic government. On the other hand, if it is necessary to have aid from the Federal level, to assure adequate medical and dental care to the people of this country, I certainly believe that it shoulud be by a plan whereby the State is given as much latitude as possible in administering and planning the problems peculiar to its own geographic, economic, and social environment.

Sincerely yours,

Charles M. Dale, *Governor.*

State of New Jersey,
Executive Department,
August 12, 1947.

Hon. H. Alexander Smith,
Princeton, N. J.

Dear Senator: This will acknowledge receipt of your letter of August 7. I am forwarding S. 545 and S. 1320 to our health department for analysis and such recommendation as the State commissioner of health may care to make.

For my part, may I say that on the basis of present information I find S. 1320 completely objectionable. Frankly, I am not enthusiastic about S. 545. Where is the Federal Government going to get its money for these new contemplated grants-in-aid to the State? I suspect that the answer to that question is fairly clear. The Federal Government will retain tax fields that properly belong to the States, or invade new fields. I again recommend that the Federal Government discontinue the so-called emergency taxes imposed during the past 15 or 20 years and concentrate on the great tasks of national defense and international affairs, leaving to the States primary responsibility for public health.

Your bill, with its commendable provision for centralizing the activities of the Federal Government relating to health, is merely one step down the road to a centralized government. All the declarations that this is not the case pale into insignificance when compared with the record of what has happened in the past in almost every instance where the Federal Government has engaged in a grant-in-aid program. Federal control follows the grant-in-aid program just as inevitably as day follows night. If this were not so it would be unnecessary for us to provide for an appeal by the State in the event it is dissatisfied with action taken by the director.

At the recent Governors' Conference one of the governors boasted of the fact that his State had no income tax, no sales tax; few, if any, nuisance taxes, and no State debt. He invited the other Governors to come to his State and see how it was done. It is not necessary to travel to a State to observe this miracle of modern financing. The records disclose that the Governor's State is being given a free ride by the Federal Government at the expense of many other States, for the State in question receives between $3 and $4 from the Federal Government for every dollar that it pays to the Federal Government. In fact, it probably receives more highway aid from the Federal Government (the great diversionist) than it can possibly use on a matched-fund basis. Of one thing we may be reasonably sure—if the Federal Government continues its present tax program the Nation will be reduced to a country of families and individuals with low income.

With kindest personal regards, I am,

Sincerely yours,

ALFRED, *Governor.*

STATE OF NEW MEXICO,
OFFICE OF THE GOVERNOR,
Santa Fe, December 2, 1947.

Hon. H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR: Reference is made to your letter of November 8 and to your previous correspondence regarding pending public-health legislation, namely, S. 3120 and S. 545.

I have gone into these measures at some length with interested officials here, and especially with the Public Health Department. While we all agree that some sort of public-health insurance should be provided, our own health department does not fully agree with the methods proposed in either bill. Since these measures are somewhat controversial, I feel it best that we be guided by the thinking of the members of our own Congressional delegation, who are on the ground and can keep abreast of all developments.

We will, however, continue to study this situation and if it is felt that a definite recommendation should be made at a later time it will be forwarded to you as soon as possible.

With best wishes and kindest regards, I am

Yours sincerely,

THOMAS J. MABRY, *Governor.*

STATE OF NEW YORK,
EXECUTIVE CHAMBER,
Albany, August 12, 1947.

Hon. H. ALEXANDER SMITH,
Princeton, N. J.

DEAR ALEX: I have your letter of August 7 and appreciate very much indeed the courtesy of your inquiry concerning the health bills before your committee.

My own position is very simple. Three years ago, in the belief that Government action could procure a better health program for our people by a program of general health insurance, I procured authority from the legislature for a 19-man commission who, with adequate funds, could make an extensive study and produce a program. I appointed a very representative group of doctors, nurses, and laymen. Both the chairman and the research director were strongly in favor of such a program. I read the hundreds of pages of research data and the hundreds of arguments, and became absolutely convinced that in the face of all known experience of man, such a program would be a costly failure and might also tear down the standards of the medical profession in the process.

If that is correct for a State, it is even more correct for the National Government, in my opinion.

We have extended our own State health service widely in many directions. Whether more Federal subsidies will do any good, I do not know. My new health commissioner, Dr. Hilleboe, may have strong views of his own, and as soon as he is thoroughly worked into his new job, I will ask him to write to you.

Meanwhile, I hope to see you sometime soon and have that long delayed lunch of ours. When you are going to be in New York or near Albany, won't you let me know, so we can try to make our schedules coincide?

With warm regards.

Sincerely yours.

THOMAS E. DEWEY, *Governor.*

STATE OF NORTH DAKOTA,
OFFICE OF THE GOVERNOR,
Bismarck, September 18, 1947.

Hon. H. ALEXANDER SMITH, *Senate Office Building, Washington, D. C.*

DEAR SENATOR SMITH: An answer to your letter of inquiry of August 7, relative to a National health policy, has been much delayed pending investigations into the problem by both the State health officer and myself. I am enclosing a copy of a letter that I received from Dr. Russell Saxvik, state health officer and director of the State Health Department for North Dakota. Dr. Saxvik is a native of our State, who received his common school and secondary education in the public schools of Bismarck, N. Dak. He is fully familiar with North Dakota conditions and his letter summarizes them in excellent fashion.

I am opposed to the approach to the health problem that is outlined in S. 1320 and am confident that a big majority of the people of North Dakota are of the same opinion. Should it be deemed necessary to open new avenues of approach from the National level the plan outlined in S. 545 would be much more satisfactory.

I feel that our biggest need in North Dakota at the present is adequate hospital and clinical facilities and also a materially larger number of qualified doctors and nurses.

Sincerely yours,

FRED G. AANDAHL, *Governor.*

NORTH DAKOTA,
STATE DEPARTMENT OF HEALTH,
Bismarck, September 15, 1947.

Hon. FRED G. AANDAHL,
Governor of North Dakota, Bismarck, N. Dak.

DEAR GOVERNOR AANDAHL: In compliance with your request for information in the questionnaire letter of the Honorable H. Alexander Smith, chairman, Subcommittee on Health, I offer the following information:

1. The Senator's first question, "What percentage of the population of the various States is not getting adequate medical care today and what classes * * *" poses the most difficult of his queries.

The term "adequate" medical care can be taken to mean many different things. So for an answer to the first question, I have broken the problem down into four categories.

(*a*) A cost analysis: The necessity in determining what percentage of the population has an income sufficiently large to afford complete medical care is of prime importance. So many factors are involved in accurately determining this analysis that definite data will not be available until considerable research has been made into this problem. It is becoming increasingly evident in analyzing the statistics that a fairly large percentage of the population, at least 25 percent, would be faced with a tremendous economic responsibility should serious illness be encountered. These individuals could not readily afford a part or any of the expenses incurred. It is evident also that many families in the middle economic bracket are budgeting their incomes through health insurance of many types to offset unexpected medical and hospital expenses.

It is not surprising then to find that 2.5 percent of the total population are receiving medical services through the department of welfare, and neither would it be surprising to find that approximately another 2 percent of the total population are receiving care through the State department of health, benevolent societies, charitable institutions, and other social agencies. It is my opinion that the indigent in the State receive reasonably adequate medical care. The organized laboring class, the farmers, the individuals having prepayment health insurance policies, and the higher incomed group also receive adequate care. However, the low income salaried workers, usually classified as the unorganized laborers and the white-collared class, are still pitifully short financially when faced with a catastrophic illness.

When a complete study on available statistics has been made with the aid of a competent statistician, we will be pleased to forward the compilations to your office.

(*b*) The availability of physicians: The greatest difficulty that we have in the State apparently is the shortage of physicians in rural areas. Three counties in North Dakota have no physicians. In the 19 counties which have less than 5,000 population, 72 percent of the people are not within reasonable distance to a physician. They are more than 15 miles from his office. It is impossible, of course, to determine the availability of a physician for any group of people in the rural areas during severe climatic conditions.

It is my opinion that the general shortage of physicians, particularly in the rural communities, represents the greatest lack of adequate medical care to be found in our State at the present time.

(*c*) The availability of hospitals: Practically on a par with the shortage of physicians is found a shortage of hospital facilities. It is without question that a person could receive adequate medical care should be within reasonable range of a hospital. In North Dakota's unincorporated territories, having a total population of 36,221 there are no hospital facilities. Not until we find cities and villages of over 1,000 population do we find any semblance of these facilities, and it is only in cities with more than 20,000 population that there are enough beds to serve that total area.

It is my belief that the people of North Dakota are entitled to more complete hospital facilities, and as you know, every effort is being made to get these small community hospitals ready to service their respective areas.

(*d*) The availability of public health facilities: Adequate medical care should also refer to preventative care in which category falls the term "public health facilities." Only 30 percent of the State is covered reasonably well by complete public health services; such as public health medical services, nursing services, and sanitary services. There are some public health facilities with a nurse or sanitarian covering about 70 percent of the State, servicing one phase of public health program. The actual shortage of public health units in the State cannot be accurately measured in terms of dollars and cents or the value that they give to the general populace in preventing serious illnesses.

In restrospect, the for categories, when fitted together, should give the total pictre of adequate medical care for all classes of people. Each point is intimately associated with the other, and it is beyond my scope of reasoning at this time to see the over-all picture in the State.

The Senator's second question: "What States would approve a compulsory tax plan such as S. 1320 calls for, with a Government-supervised medical service." I do not believe that S. 1320, contemplating a compulsory taxation plan, is in any way an answer to the problems here in North Dakota. If the people are to be taxed in the manner set up under S. 1320, it could well mean that it would be years before they would actually receive the full benefit from their money. From information available, the medical profession, the dental profession, and the hospital profession have gone on record as being opposed to such legislation, and whether or not the bill has merit and might be the answer to the problem, I cannot justify the acceptance of legislation that is contrary to the beliefs of these professions through which we must work. Lastly, the compulsory aspects of this bill are not in keeping with our ideas of sound government as practiced in North Dakota where it is still believed by the majority of people that they have the privilege of determining their own methods of health protection.

The Senator's third question: "What States would prefer that S. 545 plan leaving to the States the determination of policy—that is, compulsory or voluntary group health plans," would be the bill to endorse, providing that you wish to endorse a bill of this nature. S. 545 has been approved by the medical association, the dental association, and the hospital association as being the most practical bill yet devised for a Nationwide health program. As far as our State is concerned, we have found that the use of Federal grants with the right to develop our own program has been most satisfactory. From information received from the executive secretary of the North Dakota Medical Association, it is stated that the State society would also back this form of health insurance.

It is my opinion that through our own legislative action can the people of the State determine whether they are willing to accept such a program by allocating funds for matching purposes. The burden of the responsibility is then on their shoulders.

Concerning the Senator's further question: "How do you handle the health problem in your widely scattered rural areas," the best answer I can give is that the people in North Dakota, particularly in the rural areas, are very much aware of their health problems. Through continued education, they now believe that if they personally strive to better their situation by building small community hospitals and securing competent medical personnel that the rural areas will have the answer to their problem.

The new Federal aid-to-hospitals program is working exceptionally well in our State. We are the first State in the United States Public Health District No. 7 to have submitted a State plan for hospital construction to the Surgeon General for approval. It remains to be seen whether or not the requirements set down by the Government regulations will be so stringent as to eliminate many worthwhile projects. The biggest problem that we have yet to face in North Dakota on the Federal aid-to-hospitals program is that not enough money has been allocated to our State to aid the communities in their hospital construction projects. We have evidence that at least 40 communities in North Dakota have raised a sufficient proportion of money to meet Federal requirements for this work. Yet the money allocated to this State for matching purposes is enough to build approximately 116 beds, or the equivalent of 4½ 20-bed hospitals. This necessitates the unfortunate task of requiring communities to wait until it is their turn to receive Federal money to aid in the construction, or to start building their hospitals now when interest is extremely high and some of the money is available, without any hope of receiving a Federal grant.

Respectfully yours,

(Typed) Russell O. Saxvik, M. D.,
(Signed) R. O. Saxvik,
State Health Officer.

State of Ohio,
Office of the Governor,
Columbus, December 1, 1947.

Hon. H. Alexander Smith,
Chairman, Subcommittee on Health, United States Senate,
Washington, D. C.

My Dear Senator Smith: Upon receipt of your letter of August 7, I referred it to the director of health, Dr. John D. Porterfield, who has now furnished me with material relative to your questions.

In reply to your first question, it is the opinion of the director of health that approximately one-third of the population of Ohio is not obtaining adequate medical care at the present time, and he lists as reasons for this—inability to pay, insufficient medical personnel, inadequate treatment facilities, and uneven disposition of personnel and available facilities—the classes getting the least adequate medical care being the rural population, and the urban middle-class, self employed class. State and local welfare funds, together with medical center dispensaries now provide for the very poor. Blue Cross and Medical Indemnity, Inc., provide in large part for employed groups.

In answer to your second question, it is my own opinion, which I am sure coincides with that of the great majority of Ohio residents, that a compulsory tax plan such as S. 1320 calls for, with a Government medical supervised service, is neither necessary nor desirable.

With respect to your third question, I am assuming that when you ask "What States would prefer the S. 545 plan," you mean as between S. 545 and S. 1320.

I am satisfied that Ohioans generally would consider S. 545 as more preferable, or more properly speaking, less unpreferable. I believe I am correctly reflecting Ohio's sentiment when I say we do not favor socialized medicine. If governmental assistance is necessary in the field of medical care, of which fact I am not yet convinced, then obviously the development of such a plan patterned to the individual needs of a State is preferable to a National, centrally administered program. Ohio now has legislation on its statute books which permits the organization both of hospital service groups and medical care groups. It would seem wise to permit further study of the efficacy of such programs before the enactment of any further Federal legislation.

With respect to your question as to how the health problem in widely scattered rural areas is handled in Ohio, I am advised by Dr. Porterfield that the local relief offices are in some instances inadequate because of the lack of sufficient medical personnel and treatment facilities, although both shortages are being remedied. The State health department is unable to expand its present activities because of its present operating budget, and I am hopeful that this situation also will be alleviated next year.

In answer to your second specific question, the new Federal aid-to-hospitals program has not yet gotten under way in Ohio. Our State plan is just being completed, and at a special session of our general assembly to be held this week I am asking additional funds for that purpose. If this appropriation is made, Ohio will be in a position to make specific recommendations for the Federal grants-in-aid allocable for hospital and health center needs in this State.

I trust that the foregoing may be of some assistance to you in the study of what I recognize to be a very difficult and very complex subject.

Sincerely yours,

THOMAS J. HERBERT,
Governor.

THE JOURNAL,
THE OKLAHOMA STATE MEDICAL ASSOCIATION,
September 4, 1947.

Hon. H. ALEXANDER SMITH,
Senate Office Building, Washington, D. C.

Dear Senator SMITH: Your letter addressed to the governor of each State in the Union has come to my attention. For a long time I have been interested in the oft recurring Wagner-Murray-Dingell bill, now S. 1320, and I am disturbed about the alternative of accepting this bill or S. 545. In my opinion the medical profession of Oklahoma is not ready to approve either. I am wondering if you would consider the feasibility of giving the governors of each State a third choice and pose a question like this: "What States would prefer to have no part in a health plan proposed and subsidized by the United States Government?"

In confirmation of the fact that I have been following this threat to medicine as a free enterprise, I am enclosing a copy of my letter to Senator Wagner under date of June 1945. I believe you will find some paragraphs in this letter of interest to the committee, particularly the one referring to individual problems and needs of individual States.

Thanking you for your interest in this vital proposed legislation, I am,

Very sincerely,

LEWIS J. MOORMAN, M. D.
Editor in Chief.

(Dictated but not read.)

This letter is published through the request of the president, the editorial board, and several members.

JUNE 25, 1945.

Senator ROBERT F. WAGNER,
United States Senate, Washington, D. C.

Dear Senator WAGNER: As a member of the editorial board of the Journal of the Oklahoma State Medical Association may I acknowledge the receipt of your letter and the copy of your speech before the Senate. I feel that you should not be surprised when I tell you that we have no space in the Journal for this material. Your proposals with reference to medical legislation are well known to the doctors of the State because much space in the Journal has been occupied with informative articles warning the doctors and the people against regimented medicine in any form. Since your bill has been reintroduced, this policy shall be continued.

Now, speaking as an humble citizen and a member of the medical profession, may I say that I could be more patient with you and your program if I did not feel sure that you are at least partially aware of what you are trying to do to a great free enterprise which has given to the American people the best medical service ever vouchsafed to any comparable nation.

Medicine has reached its present high mark through an evolutionary process following the path which nature walks. Any change which cause a deviation from this path is dangerous to the welfare of our Nation. Washington bureaucrats are now knee deep in trouble because, contrary to nature's way, they have plowed up, turned under, burned, and killed products of the soil and, without sufficient knowledge of fundamentals, they have monkeyed with supply and demand and paid people not to plant, or unwisely to plant less than they, as farmers, believed they should. It is my understanding that you are having a little trouble with your existing so-called social security. If you had struggled through 8 years (the minimum for doctors) of formal education in Government and statesmanship before you entered politics, I might feel more secure about your part in lawmaking, but even then I would question your ability to pass judgment on the merits of medical service and to provide ways and means for its application and distribution.

Bismarck instituted social security including compulsory health insurance in Germany with the avowed purpose of placing the common people under obligation to the Government. A bit of political expediency which, in addition to other evil consequences ultimately snuffed the rising flame of medical science in Germany. Who can say how much the program had to do with the mass psychology which prepared the way for Hitler and his followers. Friedrich Schiller, who laid down the principles of democracy and set forth the tenets for which we fight today, would turn over in his grave if he knew what you and your coworkers are trying to do to a free people. In this connection it is significant that Schiller became an exile from his own Wurtemberg rather than practice medicine under the regimentation of Duke Charles. Under German social security the quality of medicine declined and the costs mounted. No Heinies, Goethies, or Schillers appeared to stabilize a waning social order. Schiller had the courage to walk out on his imperious duke, Goethe, as Minister in Charge at Weimer, under the roar of Napoleon's cannon at nearby Jena, bravely waited to face the victorious emperor. The grand duke and his court had fled but Goethe was not afraid. Heine had the courage to place his finger on the obstacles which doctors were meeting in their attempt to advance the cause of public health throughout the civilzed world, namely business interests and tenement owners often operating under political protection.

When the end came to Germany, courage was supplanted by flight and self-administered poison. The latter often retained in the mouth where at the opportune moment chattering teeth might nip the vial and release the lethal dose. No Nipponese faith inspires this cowardly act. Rather, it represents the mark of stark degeneracy under a dissolute and wrecked government. If you cherish the approval of posterity you should reconsider your plans for medical service and promptly retrieve your proposal legislation. If your bill should be enacted into law, ultimately the people will be pinched by the yoke and they will blame the perpetrator. If the people and the doctors of your own State should choose to follow your proposals, I would have nothing to say. But I am wondering if you realize the United States reaches from ocean to ocean and that the respective States sprawling across the continent present variable and often distinct social, economic, political, and even medical problems. From a medical viewpoint, after public health does its job, the solution of these problems belongs to these respective States. Speaking for Oklahoma, we will come up to the draft board as physically fit as your New Yorkers, we will be more typically American, we will last as long in battle and be a little quicker on the trigger. For 20 years I have visited New York two to three times annually. How many times have you crossed the Mississippi to see us? Do you know what we need? We love you and we enjoy fighting for you and we expect to continue putting food on your tables but please leave us freedom in these essential pursuits. Here's hoping you will have Oklahoma turkeys and Kansas City steaks for Thanksgiving and Christmas.

Now that we do definitely disagree on this controversial problem, why not set up the credentials for our individual opinions. I should not venture to be so personal if the issue were not so ponderous. The following I have taken from Who's Who in America, which no doubt had your approval.

"Wagner, Robert Ferdinand: B. S. degree from the College City of New York, 1898; LL. B., New York Law School, 1900; widower; one son Robert F., Jr. Practiced at New York City; member New York Assembly, 1905–08, Senate, 1909–18; Chairman, New York State Factory Investigating Commission, 1911; Lieutenant Governor of New York, 1914; justice, Supreme Court of New York, first district, 1919–26; assigned to appellate division first department, 1924 (resigned); member United States Senate since 1927; chairman, Senate Committee on Banking and Currency. Democratic leader, New York Constitutional Convention, 1938. Introduced National Industrial Recovery Act, Social Security Act, National Labor Relations Act, Railway Pension Law, United States Housing Act of 1937, and other social and economical legislation in Senate."

I am a native of Kentucky and I grew up in a small town. Eight years of my life were spent in preparation for the practice of medicine, three of these school years on borrowed money. Compared with the present Federal subsidies for medical students, borrowing was good fertilizer for the growth of character. I am glad that I borrowed from Uncle Bob instead of begging from Uncle Sam. In a middle State, east of the Mississippi, I was temporarily a doctor on horseback 25 miles from a railroad. For 6 years I was a horse-and-buggy doctor, on the plains, replacing my intern service by practice in dugouts, sod houses, and prairie shacks. I have been in general practice in a modern small city and later in highly specialized practice with a private sanatorium. One year of medical studies in Europe; 20 years teaching medicine in the University of Oklahoma; 3 years as dean of the same school. During my deanship I was superintendent of the University Hospital and the Crippled Children's Hospital, both having active out-patient departments serving the whole State.

I have been president of the local tuberculosis society and head of a free tuberculosis dispensary for 27 years and a member of the National Tuberculosis Association Board for a corresponding period of time. I have been an humble student of the history of medicine during my professional career and have tried to correlate and integrate the various phases of medical progress during the past 2,500 years.

Through these various interests and intimate contacts with doctors, medical students, and patients of all classes, I have a feeling that I may know something about what the American people want and what they need in the way of medical service and what a radical change may do to the high purposes which now dominate the profession. Though this may be difficult for you to understand, I can truthfully say that with few exceptions, doctors are interested in the welfare of the people and not in their own promotion.

Please leave my medicine on this tripod, the patient, doctor, and God. The patient and the doctor usually find their relationship mutually helpful. When they fail in this they are free to make changes or adjustments. God seems to be interested in both and exacts no accounting except reasonable skill and the exercise of conscience, and fortunately he presents no interminable, incomprehensible blanks to be filled out in triplicate.

This lengthy discussion has been long in my system, but I could never presume to trouble you with it until your recent communication provoked this response. Without malice toward you, I am opposed to your program because I am in favor of charity toward all. In closing, may I urge you to study and try to realize that you and I would not be indulging in this controversy if medicine in the United States had not kept abreast of scientific and mechanistic development in other fields. Our old-age problem is pyramiding because American medicine has been good enough to double our longevity in the short period of our national existence. Today if it were not for preventive medicine and sanitary engineering (also medical), the vultures would be roosting on the dome of the Capitol and defiling the most beautiful city in the world with filthy excrement resulting from the reconverted carrion picked from the bones of Congressmen, bureaucrats, and Government employees, who if they are not careful may do to us what Bismarck did to Germany and swing the medical pendulum back for a long and annulling period of decline.

Medical science can never click with the clock, medical progress can never successfullly stem the obstacles arising through directives and senseless paper work—even the willing spirit may grow weak under the domination of flesh which is not a part of its own carnal habitat.

Respectfully and humbly submitted for your consideration.

Sincerely,

LEWIS J. MOORMAN, M. D.

State of Oregon,
Executive Department,
Salem, August 30, 1947.

Hon. H. Alexander Smith,
United States Senator,
Chairman, Subcommittee on Health,
Princeton, N. J.

Dear Senator Smith: We appreciate the opportunity of commenting on the proposed plans for bringing wider medical service to the people of this country.

Oregon is favored in having one of the best health records of any State in the United States. These high standards of medical care are being extended and improved on a voluntary basis. Obviously, there are still many deficiencies, but these are being sought and corrected as rapidly as limitations of professional personnel, medical knowledge, and basic economic status will allow.

1. (*a*) It is difficult to give an estimate as you have requested because of the variation in the meaning of adequate medical care. However, keeping in mind available professional personnel and the economic conditions of this particular time, we would estimate that among persons who desire needed medical care no more than 5 to 10 percent are not receiving it. As one index for this estimate we know that 95 percent of all births in Oregon are attended by qualified physicians and that most of these births occur in hospitals or homes licensed and inspected by the Oregon State Board of Health. Composing this group needing medical care are certain welfare cases, persons with limited incomes and too great pride to take advantage of available facilities, and persons in certain isolated areas where facilities are distant and difficult to reach.

In addition, we recognize that a considerable group of persons (possibly as many as 20 percent of the population) suffer from symptoms which they do not recognize, or if recognized do not seek or desire qualified medical care because of religious belief, fear, inertia, or lack of understanding of its significance. There is also a small number of persons who are afflicted with diseases which are catastrophic in certain cases; for example tuberculosis, poliomyelitis, rheumatic fever, cerebral palsy, for which family funds are inadequate and community facilities are lacking or inadequate. Extension of public-health programs under existing types of legislation, particularly with emphasis on increasing public-health facilities and personnel and improving case-finding and health-education programs, is necessary.

In answer to questions 2 (*a*) and 3 (*a*) should comment that Oregon favors States' rights and determination of policies.

1. (*b*) The health problem in widely scattered rural areas is being met through improvement in roads, extension of public-health programs through organization of district health departments, and through encouraging physicians to locate in rural areas. Construction of hospitals and clinic facilities in rural areas will help implement the location of physicians and dentists in these areas.

2. (*b*) The Federal-aid-to-hospitals program has increased a real interest in providing better hospital service throughout the State. The hospital survey and planning now being carried on should, not only in themselves but with the financial assistance being made available by the Federal Government, help a great deal in the improvement of hospital facilities in the State.

Very truly yours,

Earl Snell, *Governor.*

Commonwealth of Pennsylvania,
Governor's Office,
Harrisburg, October 17, 1947.

Hon. H. Alexander Smith,
United States Senator, Princeton, N. J.

Dear Senator Smith: This is in further reply to your inquiry of the 7th of August.

The professional people of our department of health are one with the medical profession of Pennsylvania in supporting S. 545 at the expense of S. 1320, the modified Wagner-Murray-Dingell bill.

This preference is based very largely on the fact that it offers opportunity for the States to develop medical-care programs adaptable to each State's specific needs and preferences, that it does not impose a further Federal tax on the already burdened individual, that it recognizes the autonomy of the States, and is a refreshing move away from a paternalistic Federal Government. The passage of S. 1320 would send the country further down hill to socialism or worse, contrary to what we believe to be the will of the people, the majority of whom want to see reestablished the fundamental governmental philosophies which made America great.

The question of the percentage of population not now getting adequate medical care is not to be statistically answered. The ratio of physicians to total population in this State is about 1 to 780. Their distribution naturally has a definite bearing on availability of medical service. It is the studied opinion of our department of health that the percentage of our population not getting adequate medical care is low, perhaps relatively negligible. With very few exceptions, practically all even of our rural areas are studded with relatively accessible hospitals, and no community in the State is prohibitively distant from some hospital.

The population group most likely to be involved in inadequate care is that which comprises neither the poor nor the rich. The latter of course can purchase; and the poor, through our hospitals, practically all of them nonprofit and as such eligible for rather generous State assistance, can get at no or at trifling cost the services which the wealthy buy. It is the in-between group, especially its lower layers, which really feels the pinch.

Prepaid hospitalization (the Blue Cross) is popular, especially among the population group last mentioned. The State medical society's plan for prepaid medical care is way beyond the experimental stage. They have enrolled more than 120,000 and the number of subscribers is constantly and rapidly growing. The State department of public assistance furnishes medical and dental care by the physician or dentist of the patient's choice and pays for needed drugs, under its program, for the very poor of the State.

With respect to the handling of health problems in the rural areas, Pennsylvania may be a little more fortunate than many of the other States in that the State health department since 1905 has been directly responsible for all rural public health work and has established in every county the equivalent of the present day county health unit lately making so much progress, particularly in the South and some other sections of the country. Public health work is, therefore, not patchy throughout the Commonwealth. The department of health maintains one or more chest, venereal disease, and maternal and child health clinics in every county, provides periodic crippled children's clinics throughout the State, maintains three tuberculosis sanatoria with a combined bed capacity of 3,300, and a crippled children's hospital with a capacity of 350. It is embarking on a program of rheumatic heart disease control, including the maintenance of heart clinics, a number of which have already been established. Its cancer control program includes the support of cancer clinics in eligible hospitals throughout the State and assistance in the equipping of hospitals with X-ray machines for the X-ray treatment of cancer. There is no charge made for any of these department services, including hospitalization in its tuberculosis sanatoria and crippled children's hospital.

The federally aided program to hospitals got off to a somewhat late start. The survey phase of that project has just been completed.

In closing, may we repeat our definite opposition to the passage of S. 1320 and our preference for S. 545. To our mind, in any consideration of these two bills, there is much more involved than the physical welfare of our people. The passage of S. 1320 will unquestionably push the country further to the left and the passage of S. 545 will bring it toward the right.

Sincerely yours,

JAMES H. DUFF, *Governor.*

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,
DEPARTMENT OF HEALTH,
November 25, 1947.

Hon. H. ALEXANDER SMITH,
Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

DEAR SIR: I regret this delay in answering for Governor Pastore your letter of August 7, 1947. Upon receipt of that letter he requested me to make a study of the health needs of the people of Rhode Island and forward you the information requested.

I have reviewed S. 1320 and S. 545 with members of my staff and your letter gives an excellent résumé of the two bills. As we review the situation in Rhode Island we believe that all classes of population are getting adequate medical care. Seventy percent of the State's population is enrolled in the Blue Cross. The Rhode Island Medical Society is about to set in operation a surgical care program. The State department of health is about to complete its survey pursuant to the State's participation in the Federal aid to hospitals program.

Since Rhode Island is a small State and all parts readily accessible, we have no widely scattered rural areas and consequently no health problem that cannot readily be taken care of. We feel that the health needs of the people in Rhode Island are being taken care of in a very satisfactory manner. In the over-all national situation on this problem, we do not feel we are in a position to make comment.

Sincerely yours,

EDWARD A. McLAUGHLIN, M. D.,
Director of Health.

STATE OF SOUTH CAROLINA,
OFFICE OF THE GOVERNOR,
Columbia, December 19, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: In reply to your letter of August 7 and your subsequent letter of November 8, I wish to state that I have delayed replying to your request in order that I might have a thorough study made of both bills by several parties. My first comment is that I feel that both bills are entirely too voluminous for the average citizen of the United States to interpret correctly without undue effort. I believe that there is a wealth of opportunity for a Member of Congress to scuttle both bills and write a simplified version incorporating the desirable parts of both.

Regarding the percentage of the population of South Carolina not getting adequate medical care today, our State department of health estimates that as a general rule one-third of the people are not getting adequate medical care and that an additional one-third are not getting the proper type, or complete, care. By this, I do not mean to imply in any way that many persons in South Carolina who need medical attention do not get it. However, I do not believe that more than one-third of our families are in financial position to pay for prolonged illnesses.

I cannot answer the question as to whether South Carolina would be in sympathy with a compulsory tax plan for Government-supervised medical services. If the Federal Government imposes such a tax as in S. 1320 naturally South Carolina must pay its part. If S. 545 is enacted, no one but the general assembly can say whether or not the State will appropriate matching funds.

In general, South Carolina would be inclined to retain as much control as possible over the operations of a health plan in this State.

In each of our counties we have a county health department which handles health problems. However, 15 of our counties are entirely without hospitals and many more have inadequate facilities. We are also greatly in need of nurses, general practitioners, and specialists.

The new Federal-aid-to-hospitals program has just begun and it is too early to make any significant report. We are more than happy to have it and expect that it will have far reaching effects on the health of South Carolina.

I am very much in favor of better health facilities for our people. Enclosed herewith is a copy of my inaugural address in which I have devoted section 14 to health. This section begins on page 23 and outlines my feeling generally on this very important subject.

If there is any further assistance that I can be to your committee please do not hesitate to call on me.

If you are ever in the vicinity of Columbia I would be delighted to have you as a guest at the mansion.

With kindest regards and best wishes,

Very truly,

J. STROM THURMOND, *Governor.*

State of South Dakota,
Office of the Governor,
Pierre, September 15, 1947

Hon. H. Alexander Smith,
Chairman, Subcommittee on Health,
Washington, D. C.

My dear Senator: I regret the delay in responding to your letter of August 7 concerning bills S. 1320 and S. 545. This matter was referred to the superintendent of the State board of health, but due to ill-health he was delayed in furnishing me with the results of his study and recommendations and since the first few days in September he has been confined to the hospital and I have been unable to contact him, which I would like to do before attempting to write this letter.

I am herewith enclosing a copy of the memorandum which he has furnished me and which states his position with reference to these two bills and pretty well answers the questions as to how our State handles the health problem in our widely scattered rural areas and how the new Federal program is progressing. I note, however, that he has not answered the three other questions submitted in your letter and I will attempt as best I can to answer them.

1. While I am not able to furnish you with any figures I do not believe that very many of our people are not receiving adequate medical care. Our population, as you know, is largely rural and we do not have the large class of very poor people that are to be found in the larger centers of population. I find from the records that during the past year some 40 new doctors have been licensed to practice in our State. We now have 431 practicing physicians as compared with 390 a year ago. The State board of health has estimated that we could use another 100 licensed physicians and based upon the increase of last year, if this continues, inside of 2 years we will have an adequate number of doctors. We now have a total of 95 hospitals with 2,180 beds. Health officials have indicated that an average of 4.5 beds per 1,000 population serves to cover the needs of the average community. You will note that we are approaching that average with our approximate 600,000 State population. I assisted in the dedication of a small hospital of 20 beds at Wessington Springs, S. Dak., 2 weeks ago, which is in addition to the above figures, and on September 28 a $1,000,000 new hospital will be opened at Huron, S. Dak. I am sorry that I do not have the number of beds in this hospital, but its cost is somewhat indicative of its size and number of beds.

2. The Republican Party which was elected in this State last year and received nearly 70 percent of the total vote cast had as one of the planks in its platform the following:

"Socialized medicine: We are unalterably opposed to the Murray-Wagner-Dingell bill, which would foist upon the American people so-called socialized medicine involving more studied propaganda, planned regimentation, petty grasping, and confusion by bureaucrats interfering with the practice of medicine, the selling of drugs, and making us subject to governmental directives from the womb to the tomb."

It would, therefore, seem that the people have somewhat expressed their ideas regarding S. 1320.

3. There seems to be no question but what S. 545 would be less objectionable than S. 1320, but according to Dr. Cottam's memorandum our State medical association has come to some extent at least inaugurated a voluntary group health program which will assist in taking care of the health needs of our people.

I do not wish to have your committee gain the impression that we do not have any health problems in our State. Many communities are without a doctor or hospital facilities, but with new hospital facilities being added and with many more in the planning stage, I feel that this will attract doctors to the communities where these additional hospital facilities are being furnished and that eventually these problems will be worked out by the various communities.

I feel very certain that the medical profession in our State is definitely opposed to both of these bills and that they have a feeling that our health needs will be satisfactorily met without control and interference provided by either S. 1320 or S. 545.

Thanking you for taking this matter up with me and again expressing my regrets in the delay which has been occasioned largely by the illness of Dr. Cottam, I am

Sincerely yours,

George T. Mickelson, *Governor.*

AUGUST 28, 1947.

Memorandum

To: George T. Mickelson, Governor.
From: Gilbert Cottam, M. D., superintendent, State board of health.
Re: S. 545 and S. 1320.

Answering, now, your memorandum of August 12, to which was attached copies of S. 545 and S. 1320, both of which are now returned to you, together with the letter from H. Alexander Smith, chairman, Subcommittee on Health.

I beg to advise you that I have made a careful study of both of these laws and, in addition, was present at the committee hearings on the Wagner-Murray-Dingell bill which were held in Washington last year. I am of the opinion that none of these measures would be of any material assistance to the people of South Dakota. The Wagner-Murray-Dingell bill died in committee but I was present when Senator Taft withdrew from the hearings with a statement that he was going to get up a bill of his own, which is the S. 545 and is a matching proposition while S. 1320 is on a Federal tax-basis alone.

All of these bills represent in some degree or another an attempt to force the practice of medicine out of its present channels into some form of Government control. In other words, to force socialized medicine on the people and the medical profession is the aim of the bills. I do not feel that the people of South Dakota if sufficiently informed would want anything of the kind. We have almost no industries from which wage deductions could be made and in an agricultural State like ours, the farmers would certainly want to have their own choice of physicians and pay their own bills.

You may be interested to know that our State medical association has put through the South Dakota injury-illness expense plan. Covering February 12 to June 1, the following have been announced.

Premiums written	$6,423.87
Premiums earned	$3,734.62
Losses incurred	$2,811.22
Loss ratio to premiums earned (percent)	75.27
Annual premiums potential of writings to date	$37,156.92

Losses incurred include claims paid and claims outstanding, but do not include loss expenses. Acquisition, administrative, and promotional expenses are not included in above figures.

Enrollment experience

Total number of participants	2,060
Number of participants afforded hospital or nurse benefits	1,926
Number of participants afforded surgical procedure benefits	1,295
Number of participants, afforded medical or diagnostic benefits	601

This is a purely voluntary proposition which is underwritten by the St. Paul Mercury Indemnity Co. This does not mean that the one insurance company will be given the monopoly of writing insurance but any other company which desires to write this type of insurance on the terms agreed upon by the State medical association can do so provided they are able to show the necessary financial stability such a type of voluntary insurance would require. This voluntary insurance against sickness or injury is welcomed by the members of the State medical association while, on the other hand, I feel safe in saying to you that the introduction of legislation such as is covered by S. 545 and S. 1320 would be violently resented by the medical profession of South Dakota.

Senator Smith asks two questions: "(1) How you handle the health problem in your widely scattered rural areas?" and "(2) How the new Federal aid-to-hospitals program is working?"

We now have about 100 more doctors in the State than a year ago and with good roads and good transportation, the problem of every family receiving medical attention is very much better than it was a year ago.

It is too early to say how the Public Law 725 is working since we are just now completing the State plan for submission to the Surgeon General of the United States Public Health Service and the district office at Kansas City. This State plan will make a big book 1½ inches thick and we are aiming to prepare only three copies of it; one for our own files and two for the official sources mentioned. Obviously, it will not be possible to circulate a large number of these complete State plans on account of their bulk and the unlikelihood of anyone caring to bother to read them in such size. We shall prepare a very complete summary for distribution to the press and to such individuals as civic officials and heads of organizations throughout the State. Before we submit the large State plan to the Surgeon General and the district office, we are required by law to give wide publicity to a concise statement of these plans and also to hold a public meeting here in the statehouse where any interested persons will be welcome to attend and ask questions.

Very sincerely yours,

GILBERT COTTAM, M. D., *Superintendent.*

STATE OF TENNESSEE,
DEPARTMENT OF PUBLIC HEALTH,
Nashville, August 20, 1947.

Hon. H. ALEXANDER SMITH,
United States Senator
Chairman, Subcommittee on Health,
Princeton, N. J.

DEAR SENATOR SMITH: Governor McCord has referred to me your letter of August 7 with the request that I answer your letter to the best of my ability.

First, I should like to say that I am a doctor of medicine, having graduated from a recognized school of medicine, University of Tennessee, am licensed to practice medicine in Tennessee, and I have had postgraduate training in public health at Johns Hopkins University. I have observed the developing interest in a national health program with a good bit of interest and have followed to the best of my ability the various bills that have been introduced into the Congress on this subject. I have read some of the testimony that has been given in committee hearings and I am of the opinion that few individuals, either for or against the bill, have been perfectly honest with the people and themselves, or they are grossly misinformed concerning the problems connected with medical care.

One of the primary factors has, I believe, been completely ignored. This fact relates to medical service as a commodity. Like any other commodity, it cannot be available to all until the supply exceeds, or at least equals, the demand. In the instance of medical care the supply cannot equal the demand until there exists in the United States qualified practitioners of medicine in numbers sufficient to provide this service. This statement is so elementary that I am somewhat embarrassed at the necessity of having to make it and yet I feel it is at the bottom of all of our difficulty.

The qualified medical schools of the United States are producing physicians as fast as the available facilities will permit and since this is not fast enough to supply the demand, the individual physician has a wide variety of choices concerning his location. Being a human being, it is natural that the majority will select that area in which they can do their best work, not only professionally but financially, and I am of the opinion that one is about as important as the other.

There is no type of legislation that can be passed by the Federal Congress under our present Constitution that can force any physician to select an area for practice simply because of the fact that the area does not have sufficient medical service available and even if the Constitution permitted it, it still wouldn't work because it was tried in Russia shortly after the Bolshevik Revolution. Dr. Alexander Roubakine, of Moscow, who was at one time director of all medical work in Russia, personally told me that they couldn't make it work in Russia. The better physicians even in Russia carry on a private practice.

There are two conditions prevailing in a community which preconclude a community's attracting qualified medical practitioners, one, economic; and, two, facilities with which to work. The proponents of the various bills dealing with health service have attempted to solve the first by one means or another, all proposed paying for the medical service in its final analysis. Few have given any consideration to the second factor and the nearest approach to this has been the recent act which was introduced under the name of the Hill-Burton Hospital Construction Act, now Public Law 725; however, this act is going to fall far short of meeting the need because it is set up in such a way that the community that is now without services will be unable to meet the matching requirements. The act will do some good but when the 5-year period has elapsed and if costs do not increase further, I think it will be found that only about 25 percent of the necessary beds have been provided and these will be in communities that could have provided the beds on their own initiative.

No self-respecting young graduate, other than one who is financially independent, is going to a community to practice medicine when that community does not have the facilities necessary for a respectable practice and by that I mean a hospital properly equipped. The gentlemen of the Senate and the House of Representatives probably are thinking in terms of the old cross-roads physician who practiced medicine out of a pill bag and they think all that is necessary is to furnish money, and the doctor will, through some magic, appear in the community and begin work. This cannot be done because times have changed and today, instead of practicing the art of medicine as was done 40 years ago, the physician, who is in truth practicing medicine, is practicing the science of medicine and no scientific endeavor can be carried on without proper laboratory facilities. Here, I use laboratory in its broadest sense, including all of the modern diagnostic and therapeutic aids.

If you gentlemen persist in a national health plan similar to any that have been proposed, you will provide the people of this country who do not now have medical practitioners with a group of practitioners who are finding it extremely difficult to support themselves in the more populous and economically more stable communities. They will gradually migrate to these areas where practically no service is available and the people will wake up to the realization that they have not secured medical practitioners but instead they have available a pill peddler. This man may be of some benefit psychologically to those who are not in real need of medical service, but he will be found wanting when confronted with a case of real medical need. If you think this is an idle statement, I ask you to look into the licensing practice in several of the States and I would like to cite as an example, our own State of Tennessee. During the past 4 to 6 years we have had licensed approximately 1,000 so-called naturopathic physicians, most of whom never have attended any school other than a diploma mill. The recent legislature repealed the act granting them a license to practice, but the damage has been done and they are at work in other States securing legislation wherever possible to enable them to practice there.

Other conclusive proof of the great shortage that exists in the medical field can easily be ascertained by checking the number of available positions now unfilled in State and local departments of public health; for example, Tennessee had over 100 physicians employed at the beginning of World War II and we now have in local health departments less than 30, in spite of the fact that we are offering double the salary that was offered 7 years ago. This, to me, is indicative of the fact that as long as the people are able to pay the present supply of physicians for private work, the physicians will accept that payment in preference to governmental payment even though the governmental payment is greater.

Another incidence that I would like to cite is one of our metropolitan areas in east Tennessee. Both the hospital and the physicians refused to accept Government pay on the emergency maternal and infant-care program, many of them doing the work free rather than accept the $50 fee which was paid by the State from funds made available by the Federal Government. In this area of approximately 8 percent of the State's population, only the less qualified physician, usually the osteopath, would accept a case.

I haven't a great deal of sympathy with the arguments that have been proposed by the medical profession itself; in most instances, it has been motivated by selfishness. I have heard public talks pointing out what great strides the medical profession has made under the system of free enterprise. I think I am fairly well informed on the progress that has been made in the field of medicine and I know of relatively few discoveries of any scientific value that have been made by private practitioners. Most of the discoveries have been made by men in research laboratories who were working for a salary, or by research workers in the Public Health Service, the Army or Navy; however, to be of use to the public, these discoveries must be put to use by the private practitioners.

If I should be asked what one thing is needed most, I would recommend that you concentrate on a bill that will provide preventive public health services and hospital facilities to every community in the United States, and that you leave therapeutic medicine to the private practitioner.

In closing, permit me to suggest that you read with care the third intermediate report of the committee on expenditures in the executive departments, and I should like to call your especial attention to the subcommittee's final paragraph:

"Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow-travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard.

"Approved:

"FOREST A. HARNESS, *Chairman.*
"JAMES W. WADSWORTH.
"HENRY J. LATHAM.
"CARTER MANASCO.
"J. FRANK WILSON."

With such a report being in your hands and a matter of record in the Congress, I should think that your committee could do nothing other than recommend that these two bills be consigned to the waste basket.

Sincerely yours,

R. H. HUTCHESON, *Commissioner.*

STATE DEPARTMENT OF HEALTH,
Salt Lake City, Utah, August 22, 1947.

Hon. H. ALEXANDER SMITH,
Subcommittee on Health,
United States Senate, Washington, D. C.

DEAR MR. SMITH: Your letter of August 7, 1947, to the Honorable Herbert B. Maw, Governor of the State of Utah, has been referred to this department for answer. I realize in answering your letter that the answers will to a great extent be largely my own opinion.

The percentage of population in this State not getting adequate medical care is about 30 percent, and consists of the middle class. The very poor and the very rich can either take care of themselves or have adequate medical care provided them by the State.

I believe this State would prefer the S. 1320 compulsory tax plan rather than the S. 545 plan.

In this State, we have five districts and one full-time county health unit to cover the health needs of the State. The districts comprise from four to seven counties and have a full-time health officer, a sanitarian, and several public health nurses, at least one nurse for each county. At the present time, however, these districts are not completely staffed because of lack of available personnel and funds. If sufficient funds and personnel were available, more full-time city-county units in the more populated areas and more smaller district units in the rural areas would provide much better health services to the people.

The plan and survey under the Federal and State aid-to-hospitals program is now completed and we are about ready to submit applications. The State plan, however, must be approved by the Federal Government before this can be done.

If we may be of further service, please let us know.

Very truly yours,

WELBY W. BIGELOW, M. D.,
Acting State Health Commissioner.

Copy to Gov. Herbert B. Maw.

STATE OF UTAH,
OFFICE OF THE GOVERNOR,
Salt Lake City, February 5, 1948.

Mr. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health, Washington, D. C.

DEAR MR. SMITH: I have recently been informed that I am on record with your committee as favoring S. 1320, a bill which favors State medicine.

Please be informed that this is definitely not my position. On the contrary I am opposed to the principle of State medicine.

With best wishes, I am,

Sincerely yours,

HERBERT B. MAW, *Governor.*

State of Vermont,
Executive Department,
Montpelier, September 9, 1947.

Senator H. Alexander Smith,
Chairman, Subcommittee on Health,
Senate Office Building, Washington, D. C.

Dear Senator Smith: This will acknowledge your letter of August 7 relative to your questions pertaining to S. 1320 and S. 545. Perhaps I could best answer the letter by specifically commenting on the various questions in the order as presented.

"1. What percentage of the population in the various States is not getting adequate medical care today; and what classes—that is, the very poor, the white-collar class, etc.?"

General-medical-care studies indicate that the persons of lower income brackets and the rural population groups receive a much less volume of medical care than needed for adequate care. This group and in most instances the needy, are considered to receive inadequate care. As far as I know, there has been no actual survey in the State of Vermont, which would answer this question accurately. However, on the basis of one doctor per thousand, the State would appear to be fairly well covered, but we know that the distribution of doctors is not even. I do not believe it would be out of line to estimate at least 20 percent of the population of the State as receiving inadequate medical attention. This, however, is only an estimate not based on any figures other than the distribution of physicians and taking into consideration the sparsely settled rural areas.

"2. What States would approve a compulsory tax plan such as S. 1320 calls for, with a Government-supervised medical service?"

I understand that no State in the United States Public Service District No. 1 has gone on record in approval of a compulsory tax plan with Government-supervised medical service as called for in S. 1320, although some organizations have unofficially been in favor of it, such as the trade unions. The Vermont State Medical Society is opposed to it, as well as other people in the State on the basis that it is undemocratic because it calls for the socialization of a group who are in a competitive private endeavor. Farm groups in the State have discussed it but I know of no official statement as to support or opposition to the bill. One difficulty expressed is that although all groups are in favor of some type of legislation to give more adequate medical care, they would prefer something of a more democratic nature. The fact that the estimate of 4 percent is based on present expenditures for medical care makes it inaccurate and inconsistent with the purposes of S. 1320 which assumes the people are not receiving adequate attention but are spending 4 percent of the Nation's income for this inadequate attention. Probably some type of survey should be made before setting the figure at 4 percent. This survey should ask the people how much more medical attention they would demand if tax money were used and how much of the doctor's practice is charitable.

"3. What States would prefer the S. 545 plan leaving to the States the determination of policy—that is, compulsory or voluntary group-health plans, etc.?"

All States in this district have approved the Hospital Survey and Construction Act, which operates on the same basis (the same general policy) as S. 545 and several have endorsed policies of voluntary group-health plans in the separate States. Several States in the South have set up state funds to help build hospitals under the Hospital Survey and Construction Act and New York State has a similar State subsidy law for the construction of community hospitals in rural areas. S. 545 delegates to some specific agency in each State the authority and administration of grants-in-aid from the Federal Government in a manner best suited to the needs of that particular State. In other words, there is some fluctuation possible which would enable a State to take care of its own situation as it saw fit. This seems to be more democratic.

"4. How do you handle the health problem in your widely scattered rural areas?"

In Vermont there is a hospital group Blue Cross and Blue Shield program which gives only limited services to selected groups. As a result, medical care in rural sections is handled chiefly by private physicians. I have felt that the need for more health facilities in the rural areas in Vermont was one of the crying needs of the State. As a result, I presented to the 1947 legislature a mobile-health-unit bill which would send mobile health units similar to those used in the war into the rural areas to make examinations with the hope and expectation that there would be following check-ups and medical attention where it was found to be needed. Unfortunately, this bill was killed in the senate although many groups and organizations have subsequently endorsed it. I would say that Vermont as a whole does not handle its health problems in the widely scattered rural areas well, and much can be done to improve it. Obviously, this means added expense to the State and a carefully formulated plan by its urgency makes it most desirable.

"5. How is the new Federal aid-to-hospitals program working?"

Only four States in the United States have their State plans for the construction of hospitals completed. All States in this district (except Delaware) have set up State agencies and are drafting their plans. They will in 2 or 3 months be ready to receive and process applications for funds for the construction of hospitals. The program is popular in this area and has aroused a lot of interest, but there are many more applicants than there is money to distribute. The Vermont hospital construction survey is just getting under way. Consequently, it will be difficult to estimate how effective it is going to be. There will be some difficulty in the distribution of funds on an equitable basis.

Sincerely yours,

Ernest W. Gibson, *Governor.*

Commonwealth of Virginia,
Governor's Office,
Richmond, November 13, 1947.

Hon. H. Alexander Smith,
Senate Committee on Labor and Public Welfare,
Washington, D. C.

Dear Senator Smith: Your request for information from Virginia with reference to pending measures dealing with public-health matters has been referred to the Virginia Department of Health with the request that you be supplied with much helpful data as may be available.

I might offer the brief comment that I am opposed to the principle of Federal grants-in-aid for services which are essentially the responsibilities of the States. I realize that there are many who disagree with this view and should they be in the majority in the Congress, I certainly would prefer to see legislation which leaves the administration of the programs in the hands of the States.

With kindest regards, I am

Sincerely yours,

Wm. M. Tuck, *Governor.*

Commonwealth of Virginia,
Department of Health,
Richmond, December 5, 1947.

Hon. H. Alexander Smith,
United States Senator, Princeton, N. J.

Dear Senator Smith: Reference is made to the Governor's letter to you under date of November 13 in which he states that this department has been requested to furnish you with certain factual information requested in your letter of August 7, 1947.

We regret that we have no detailed statistical data regarding the adequacy of medical care in this State. It should also be noted that the term "adequate medical care" is too intangible to be used to provide actual figures regarding percentages of population for which such care is available.' The recent hospital survey in this State has indicated that there are many rural areas in the State in which large populations and areas are served by a single physician. The hospital survey also demonstrated that certain large areas in the State are without hospital facilities except upon transportation of the patient many miles. Obviously, with the data available, an estimation of the percentage of the population which is getting adequate medical care would be too gross to be of real value.

The provisions of health services in the rural areas is accomplished through the establishment of local health departments which operate generalized public health programs. Although only 67 of the total 100 counties, or 76 percent of the rural population, are served by local health departments, it is anticipated that this activity will be expanded as rapidly as public health personnel is available.

The hospital survey in Virginia has been completed and the final plan prepared to be submitted to the United States Public Health Service for approval. It is anticipated that approval will be given on this plan by January 1, 1948.

I trust that this is the information you desire and assure you of our willingness to assist in any way possible.

Very truly yours,

L. J. Roper,
State Health Commissioner.

State of Washington,
Executive Department,
Olympia, August 29, 1947.

Hon. H. Alexander Smith,
United States Senator,
Chairman, Subcommittee on Health,
Princeton, N. J.

Dear Senator Smith: In response to your request we have compiled a few facts and figures that may be helpful in answering some of the questions on medical care coverage in the State of Washington.

In answer to your first question, relative to adequate medical care for the population of the State of Washington today, we offer the following: Under the Washington State medical bureau contracts service there are approximately 250,000 employees who are subscribing to this service and who are receiving more or less adequate medical care under the program. It has been estimated that there are only 500,000 employees on pay rolls of firms with 5 or more employees in the entire State. This means that 50 percent of all employees of the State are covered under the Bureau. The age limit in this program is 65 years in most cases. Children under 19 years of age who live at home are covered under family contracts.

Medical Bureau Coverage can be described somewhat as follows: Medical care with free choice member physician is provided at the office, in the home and hospital. Medical and surgical treatment is given for 6 to 8 months in any one sickness. Hospital and nursing services in wards are authorized. Under most of the contracts this service is provided for a period averaging 6 months. Hospitalization periods in the various bureau areas vary from 3 months to a year; the average is 6 months. Most of the contracts authorize medicines, drugs, and the use of ambulance. Chronic conditions and those existing prior to the subscriber becoming a member are usually excluded from the coverage.

Other persons in the State of Washington receiving medical care are those individuals eligible for public assistance under our public welfare program. The following table shows the number of persons on the rolls as of June 1947 and who are all eligible for this medical care:

Old-age assistance	65, 643
General assistance	11, 011
Aid to dependent children	28, 505
Aid to the blind	642
Total	105, 801

Besides this group there are others receiving medical care as for example that provided by—

1. Labor and Industries.
2. Tuberculosis control.
3. Crippled Children's program.
4. Veterans' Administration.
5. Physical restoration under Vocational Rehabilitation.
6. Care of cerebral palsy children.
7. Mental care in State hospitals.
8. City-county-State health programs (preventive).
9. Medical school programs.
10. Private agencies:
    (*a*) Orthopedic Hospital.
    (*b*) Shrine Hospital.

The above figures with the explanation would indicate that there are a good many people in the State of Washington who are receiving more or less adequate medical care under the Public Welfare Program or under the bureau plan of prepaid medical care. Without making a more complete study on this subject it would be impossible to say exactly what percentage of the population in the State of Washington is not getting adequate medical care today.

Question No. 2.

Question No. 3.

Referring to your request for information on the following matters:

"(1) How you handle the health problem in your widely scattered rural areas?"

The State of Washington is fortunate in having good basic laws relative to public health. Through stimulation of the grant-in-aid program the State of Washington has made considerable progress in the field of public health during the past 10 years. At the present time approximately 85 percent of the State is covered by full-time health departments; servicing all areas within the State, both rural and urban. It must be understood that this program is as yet not complete in that most of the full-time health departments are inadequately staffed due both to financial reasons and availability of personnel. However, the basic structure for a good health program has been developed and with additional finances and personnel we may expect to have a more adequate program in public health. Our basic laws, as mentioned above, provide for the formation of districts throughout the State on amalgamation of county bases or amalgamation between cities and counties. It is rendered to county health departments through the well-organized well-staffed State department of health and this aid is both in the form of indirect services and direct services.

"(2) How the new Federal aid-to-hospitals program is working."

The State of Washington has been the first State west of the Mississippi to submit its plan of hospital construction to the Federal Government for approval and is among the first five in the United States. It is too early to definitely say how this program is going to be of help ot the various communities in solving their hospital problems, but we feel that there has been a great deal of interest shown in the program and that something worthwhile will come of it. The State department of health, who is administering the program in the State of Washington, feels that there will be rural areas that will not be able to take advantage of the hospital subsidy for the reason that they will not be able to raise the two-thirds local matching money to match the Federal one-third. This might be remedied by the next session of Congress by making a more liberal matching basis for some poor rural communities.

Sincerely yours,

Mon C. Wallgren, *Governor.*

State of West Virginia,
Department of Health,
Charleston, September 26, 1947.

Hon. H. Alexander Smith,
United States Senator,
Chairman, Subcommittee on Health, Princeton, N. J.

Dear Senator Smith: Your letter to Governor Meadows requesting an outline of the situation in West Virginia relative to a national health policy has been referred to the State department of health for answer.

Our reply has been delayed somewhat in order to counsel with the leading health authorities of our State in obtaining as accurate information as possible for your subcommittee's consideration.

Your specific questions are herein discussed in the order that they appear in your letter.

(1) It is difficult to state with accuracy the percentage of our State population not receiving good medical care. It certainly will not exceed 10 percent, and is composed principally of the medically indigent group who are not eligible to receive public assistance from any source. Hospitalization and medical care services for the very poor group are provided by the State department of public assistance. The middle class wage earners are taking advantage of the various medical and surgical insurance plans for professional care for themselves and families. The mining and other industrial communities are served by a system whereby the employees authorize a deduction to be made from their earnings, and paid direct to the hospital or physician for hospital and medical care.

(2) From the information available it appears that West Virginia would not approve, at this time, a compulsory health tax plan such as provided for in S. 1320.

(3) As evidenced by the recommendations of our interim committee on State health legislation, and the subsequent action of the State legislature, definite indications are that West Virginia would insist upon the privilege of determining for herself the policies and procedures for health improvement most applicable to her population. We appreciate the financial assistance rendered to our State through grants-in-aid by the Federal Government for our public health program.

RELATED QUESTIONS

(1) Rural health is our greatest problem in West Virginia. Our population is approximately 72 percent rural. Recent medical school graduates are not returning to the rural areas to practice. In a few counties there is not a single practicing physician. Due to a lack of funds both from local and State levels and scarcity of trained personnel, we have not succeeded in expanding our public-health activities to give adequate service to these rural communities. Some plan must be worked out to provide medical, hospital, and public-health services for our rural people.

(2) The new Federal aid-to-hospitals program is progressing nicely. The State department of health has been designated by the State legislature as the agency to administer the law in West Virginia. Our preliminary survey and general State plan for construction have been completed and forwarded to the Surgeon General's office for approval. According to Public Law 725, West Virginia is entitled to $1,555,000 yearly for a period of 5 years. This is on a matching basis. Twice the amount received from Federal funds must be added from local or State funds. According to the survey, nine areas of our State have no hospital facilities, and, of course, these areas will carry the highest priorities. If we can avail ourselves of the opportunity offered by the Federal funds, and construct hospitals to this amount, we will supply only about 20 percent of our actual need. No funds for matching the Federal funds for construction are available at this time, and no applications for construction have been received by this agency.

I am enclosing a reprint of the annual address of the president of the West Virginia Medical Association, Dr. W. H. St. Clair, Bluefield, W. Va., entitled, "Government Responsibility for the Care of the Medically Indigent." This reprint will give you much additional information concerning medical care in our State.

I sincerely hope that we have been successful in answering your questions satisfactorily. If we can be of any further assistance to you or your committee please call upon us.

Very truly yours,

N. H. Dyer, M. D.,
State Health Commissioner.

State of Wisconsin,
Executive Office,
Madison, August 21, 1947.

Hon. H. Alexander Smith,
Subcommittee on Health of the United States Senate, Princeton, N. J.

My Dear Senator: This is in reply to your letter of August 7 requesting information with regard to various phases of the Federal health program and its application to the State of Wisconsin, with special reference to two major health bills before Congress having to do with Federal assistance.

You mention bill S. 1320 and bill S. 545. These two bills differ in their fundamental concepts in that the former would establish national compulsory health insurance, financed by Federal tax collected through pay-roll deduction, while the latter would provide aid to the States to enable them to furnish medical care for families and individuals with a low income who are unable to pay the entire cost for such services.

In reply to your first question as to the percentage of the population of Wisconsin not getting adequate medical care today, unfortunately no specific data is available. Studies on a national level in 1928–31 by the committee on costs of medical care, showed that the lack of adequate medical care was not confined to the very lowest income groups. Wisconsin data was included in that study. According to our best information, that situation still exists. Cost, and in rural areas scarcity of physicians, are important factors contributing to the problem.

Question 2 asks whether Wisconsin would approve a compulsory tax plan such as S. 1320 calls for. Somewhat similar bills setting up compulsory health insurance on a State basis have been introduced in our State legislature repeatedly for several sessions, including the one just closed, but have failed to pass. At this time at least, it would seem that Wisconsin would not approve a compulsory health-insurance plan, State or Federal.

Question 3 asks whether Wisconsin would prefer the S. 545 plan, leaving to the States the determination of policy that is compulsory or voluntary, etc. Voluntary health-insurance plans are now in operation in this State as authorized by statute. They are designed primarily for the benefit of the low-income group to provide a means of insuring against catastrophic illness by spread of risk on an insurance principle. The plans are in their infancy, and even when fully developed will not provide more than a part of the answer to the problem, but constitute a substantial step in the right direction. In the two direct service plans, Wisconsin Physician's Service has enrolled over 17,000 people and Surgical Care in Milwaukee has over 100,000 so enrolled. The Wisconsin plan, which is sold through insurance companies, has 75,000 or more. Also, historically, the State has shown preference for handling its own problems, as exemplified in unemployment insurance.

S. 545 would coordinate health functions of the Federal Government in a single agency; it would expand the activities of the United States Public Health Service; promote and encourage medical and dental research, etc. Grants-in-aid would become available to the States on a matching basis. One large national organization expresses itself as being apprehensive concerning the effectiveness of the grants under this bill, since there is no provision for minimum requirements to be met by the States in order to qualify for the funds. The American Medical Association, on the other hand, favors the bill. The State and Territorial health officers of the entire country favor the bill in principle, differing only with some of the administrative features on a Federal level.

You ask two further questions as to the situation in Wisconsin relative to how we handle the health problem in our widely scattered rural areas, and how the new Federal aid to hospitals program is working. Wisconsin's widely scattered rural areas are served by part-time local health boards, one for each town, village, and city, under the guidance of the district health units for the State board of health that cover the entire State. Enabling legislation for county, city-county, and multiple county health departments is anticipated in the next few years that will provide more efficient public health coverage. Medical care for the indigent and near indigent is provided by the physician of choice, financed by the local relief body. There are a few exceptions in which a physician to the poor is employed.

Hospital facilities are fairly accessible, but there are urgent needs for more adequate hospital facilities in many of the rural areas. These are expected to be met in part at least in the next 5 years with assistance through the Hospital Construction Act.

The new Federal aid to hospitals program is just getting under way in Wisconsin. The State-wide survey of needs and existing facilities has been completed. A State act designating the State board of health as the administrative agency has been enacted. The hospital advisory council has been appointed and the State plan is in process of completion, looking toward submission for Federal approval in mid-October. Hospital construction under the program can begin soon thereafter. Many local communities have raised funds and are organized to proceed.

Should there be further information you desire on these subjects that I am able to supply you, I shall be very happy to comply with your further requests.

Sincerely yours,

OSCAR RENNEBOHM, *Acting Governor.*

STATE OF WYOMING,
EXECUTIVE DEPARTMENT,
August 15, 1947.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: Upon receipt of your letter of August 7, same was referred to the health department and I am attaching hereto a letter from that department. However, in reading the letter, I can see that it is entirely inadequate in answering your questions, which I shall try to do to the best of my ability. I do follow health matters in the State rather closely.

Question 1. It would be my estimate that the very poor and the white-collar class in Wyoming are not getting adequate medical or dental attention. It is perhaps a rather blunt way to state the fact, but in medicine and dentistry to some extent as in everything else, people get what they can pay for, the more money they have, the better service they can purchase.

I am sure that because of a lack of finances, a great many people neglect their health until the situation becomes desperate, then seek medical care, and this often is too late.

Question 2. Whether the legislature of this State, which has always considered itself as being rugged individualistic and who have always strongly opposed Federal compulsive legislation or regimentation in any way, would approve any of the bills you mention, I could not say, but as I know the Wyoming State Legislature, having worked closely with this body for 15 years, any health program would need to always give the individual the right to select his own physician or it would not pass.

Before I could approve any health plan, it would need to make a provision that the rules and regulations recommended by the Federal administrative body be approved by the executive committee of the Governors' conference. I am fed up with all grants-in-aid programs where the rules and regulations say in effect to the various states, "It's this way or else."

Question 3. It occurs to me that this State would not only prefer, but perhaps demand a plan, giving to the States the determination of policy.

In the second series of questions, No. 1: Our health problems in widely scattered rural areas are few and far between and therefore, no organized agency exercises any great amount of supervision or direction.

No. 2. Due to the fact that a Senator of the majority party in the last session of our State legislature owns a hospital, he had sufficient influence to keep one important hospital bill from being introduced and rendered another bill unacceptable to the Federal Government by deleting the word "licensing" and inserting in lieu thereof the word "certification."

As a general statement, I would suggest legislation that would provide for the certifying of those who are unable to pay for medical care by the State board of public welfare and that every physician and dentist who is a member in good standing in his State society, be designated as a welfare physician or dentist and that the recipient of medical or dental service be allowed to present himself at the office of any M. D. or D. D. S., secure the services needed and the welfare board be billed for the charge.

I realize this method of taking care of the low-income group would be extremely costly unless the welfare departments were very careful as to who should be certified as being unable to pay for medical care.

It occurs to me that there are cases too where the recipient would be in a position to pay some of the costs and any plan should provide for such cases.

It is quite difficult to give you all my thinking on these matters without writing a thesis entirely too long; however, if any of my suggestions provokes any questions, do not hesitate to write me.

Yours very truly,

LESTER C. HUNT, *Governor.*

STATE OF WYOMING,
STATE DEPARTMENT OF PUBLIC HEALTH,
August 12, 1947.

Hon. LESTER C. HUNT,
Governor of Wyoming,
Cheyenne, Wyo.

DEAR SIR: Referring to the inquiry you received from H. Alexander Smith, chairman, subcommittee on health.

Sometime within the last 6 months, all the State and Territorial health officers were queried as to their opinions on the two bills before Congress in reference to public health, namely, S. 545 and S. 1320. Speaking for the State health department I gave my opinion that S. 545 was much to be preferred to S. 1320. It is my understanding that the poll conducted among all the State health officers indicated a great majority in favor of S. 545.

I have heard a great many doctors discuss the two bills and it is my opinion that the Wyoming State Medical Society much prefers (though there are many objections) S. 545.

In answer to the questions on page 2 of Chairman Smith's letter to you, the answer I would make is that every county in Wyoming, except probably two, has adequate medical care. We have a county health officer in every county of the State handling health problems arising therein.

The Federal aid-to-hospitals program is not progressing in our State for the reason of inadequate State legislation, as prescribed by the United States Public Health Service before Federal assistance can be given our State.

Very truly yours,

G. M. ANDERSON, M. D.,
Director of Public Health.

Senator SMITH. Mr. Falk is our first witness this morning. Mr. Falk, we will ask you to take the stand, and I will ask Senator Donnell to continue the hearings where we left off last July.

Senator MURRAY. Mr. Chairman, before we proceed with the witness, since our last session one of America's greatest statesmen and of our most outstanding citizens has advised our doctors to give up their fighting of rear-guard actions and to sincerely get behind a program to provide health insurance. That man, whose advice has never been wrong, is Bernard M. Baruch. Herewith I present his speech for the record and for the information of the committee; also an editorial by Mr. Harold L. Ickes, entitled "Man to man," being a discussion of the Baruch speech.

(The address by Bernard M. Baruch and the article by Harold L. Ickes are as follows:)

MEDICAL CARE FOR THE PEOPLE OF AMERICA[1]

(by Bernard M. Baruch)

You do me honor to ask me to talk to you about health. I almost became a doctor myself.

When I was a boy, my mother took me to a phrenologist. His office was across the street from where Wanamakers now is. He felt the bumps on my head and asked my mother what she expected to do with me.

She replied, "I am thinking of making him a doctor."

"He will be a good doctor," said this phrenologist, "but my advice to you is to take him where they are doing things in finance and politics—he might even make good there, too."

It has been a long detour for the prodigal. He has returned.

In many ways I am sorry I did not become a member of this noblest of professions. For I believe we approach a great adventure in health. That is our goal. I think it obtainable. It would be gratifying to take a more active part in it.

All my thoughts on medicine are colored by memories of my father, Dr. Simon Baruch. He was the wisest man I ever knew. He pioneered in surgery, physical medicine and "incurable diseases." Often, I heard him tell prospective medical students:

"Do not enter the medical profession to make money. Study medicine only with the idea that your greatest compensation will be knowing that you help your fellowman. Do not expect gratitude and you will never be disappointed."

As chairman of the War Industries Board in the first World War, I realized how important to defense was the health of our citizens. That awareness was reinforced many fold during this past war.

In preparing a report for the late President Roosevelt on manpower, I was shocked to learn at least four million men had been rejected as 4–F's—unfit to defend their country, some, not all, of these defects were preventable.

How much more shocking would have been the record, if everyone had received the same examination?

Since then, I have given the problems of medical care much thought. It deeply concerned me that we not fail the returning veteran, so I studied their medical needs. From that, it was only a step to related problems of general medical care for all.

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[1] Address delivered at the Biltmore Hotel, New York City, November 19, 1947, at a dinner sponsored by the Medical Society of the State of New York, the Coordinating Council of the Five County Medical Societies of Greater New York, and the Greater New York Hospital Association.

Soon I was up to my neck in reports, statistics, speeches, congressional hearings. I conferred with many persons, doctors and nondoctors, experts and amateurs.

May I tell you some of my conclusions. They may not be particularly new to you, pioneering this field. They may be helpful, coming from a nonprofessional mind.

But before I list them, I would like to point out that the medical science and art have conferred a new and great benefit upon society in the last generation. The years of our lives have been heavily increased. This helps not merely the individual, who wants to go on living—and living in dignity and self-respect—but all the people to live more comfortably and freer from fear.

And now to go on with my exposition:

There is no question—the need for more medical care exists.

Also, there is no question this need will have to be met.

The problem is how.

All over the world, the masses are stirring for higher living standards. Improved medical care is a foundation of that better standard. Without good health, of what advantage are higher wages or shorter work hours, better education or greater leisure?

The families whose earnings disappear with serious illness—the many who suffer disease which your skillful diagnosis and treatment could have prevented or halted—or whose limited means bar them from the medical attention available to you and me—these people will not remain content.

This striving of the masses for better living is felt everywhere. In health, your profession must steer that surging tide into channels of improvement. Then, the surge does not overspill into the revolutionary flood, which washes away more than it brings.

One of the last things Woodrow Wilson wrote—called "The Road Away From Revolution"—was this:

"In these doubtful and anxious days when * * * the road ahead seems darkened by shadows which portend dangers of many kinds, it is only common prudence that we should look about us and attempt to assess the causes of distress and the most likely means of removing them."

That was Wilson's method—to assess portending dangers, and anticipate them by timely action. So, he proposed the realistic League of Nations, which men rejected as a dream—and got a nightmare. Wilson knew social change was inevitable. He worked to steer that change into orderly channels.

You should take that as your guiding star.

Society usually divides into three broad groups.

At one end—the left end—are those who burn with a passion to change everything as quickly as they can—if not quicker.

At the other—right end—are those who want things just as they are.

In the middle are people, like Woodrow Wilson, to whose school I belong, who believe in intelligent progress and seek to guide it.

What differentiates these three groups is their attitude towards that vital element of life—Time.

The left-enders feel time panting hot on their necks.

The right-enders use time to fight rear-guard actions, all the way.

The middlers—sometimes both left and right call us "muddlers"—seek to come to terms with time, preserving the best of the past, discarding the outworn, and moving on to a better future.

In the matter of adequate medical care, too many doctors have been fighting a rear-guard action for too long. I feel I must warn those doctors—time is running against them. The medical profession has justly earned great influence in the community. It can keep that hold only as it moves forward. It will lose that hold if it has nothing but objections to offer, if it has eyes only for what not to do.

We must look for what can be done—and do it.

The great question is how? I do not want to seem to say I know the answers. We do know the public is demanding better and more medical service through some action—political or otherwise.

What is this adventure in health I see dawning, and towards which you all have been keeping the doctor's vigil through the night? This adventure, which you will have to lead—or it will fail—has many elements:

1. More and better doctors—in more places.
2. An immediate, complete survey to modernize medical education, with greater emphasis on chronic and degenerative diseases, mental hygiene, and preventive medicine.

3. More hospitals more evenly spread through the country.
4. Less specialists, more general practitioners.
5. Reorganize medical practice, stressing group medicine where needed and voluntary health insurance.
6. For those who cannot afford voluntary insurance, some form of insurance, partly-financed by the Government, covering people in by law. I would call this "compulsory health insurance," if that term's proper meaning had not been lost.
7. Increased medical research.
8. Greatly expanded physical and mental rehabilitation.
9. Education to make health a national habit.
10. A vigorous, preventive medical program, reaching everyone, children above all.
11. A new cabinet post for health, education, social security.
12. Creation of a nonpolitical, watchdog committee to safeguard progress in medical care for veterans.
13. Increased numbers of well-trained nurses and technicians.
14. Adequate dental care.
15. A stabilizing economy—inflation will make worthless any health program or anything else.

Each of these would take a speech by itself. I can but sketch some of them.

Even the least ambitious schemes for improving the Nation's health require more doctors, all competently trained. Why aren't more doctors being educated? In studying that question, I was struck by how expensive training a doctor has become—in dollars and in time. In its fine report on "Medicine In The Changing Order," the New York Academy of Medicine states:

> "* * * there seems no alternative other than government aid if educational standards are to be raised or even maintained * * * If medical schools are to continue as centers of research * * * here also government aid may be necessary."

If science and medicine ask the Government for aid—which even the conservative deems necessary—they must expect he who pays the fiddler will call the tune. This means the Government will rightly insist upon no discrimination in medical care because of race, color or creed. It will rightly insist upon opportunity for all to enter the profession and advance on the sole basis of ability and character—without restrictions of race, color, creed—or sex. And, I hope, without fear of, or favor from, the State.

Minimum standards should be set for institutions getting financial aid.

How much more the Government is likely to insist upon will depend upon the more progressive leaders in your profession.

According to the Academy's Report—I quote—"there has been no fundamental reorganization of American medical education since about 1910." That finding certainly calls for your profession undertaking—now—a most thorough, down-to-earth survey to modernize medical education, making recommendations so boldly inspiring the people will gratefully back them. No one can draw up a better program than doctors.

Chronic illness and preventive medicine deserve greater attention. In all fields—I hope in war as well—there is a new accent on prevention. From answering fire alarms, our thinking is progressing to fireproofing.

Preventive medical care should commence as close to the beginning as society can reach. I favor a major, sickness-prevention drive at the public-school level. This should include compulsory examination of all children at regular intervals. Means should be made available for correcting defects disclosed.

How wonderful, if children were taught how to properly eat, sleep, sit, stand, play and take care of themselves, developing both the knack for getting along together, and self-discipline—physical and mental!

Even when medical care is available, many adults neglect or refuse to use it—often because of social taboos, as in venereal diseases, or psychological dreads, as in cancer and tuberculosis. These attitudes reflect our not having outgrown the awkward age in thinking about disease and health. We do not really have a grown-up, national health habit—although we are getting there.

People need to be educated on the virtue of medical care; how to use it; how to prevent disease. The greatest asset of any nation is a healthy, educated citizenry.

And now to what is perhaps, the toughest problem—how can better medical care be extended to those who cannot afford it?

Your organizations have been particularly active in pressing voluntary health insurance. You and others have proven group insurance to be a sound, practical way. That is a great achievement. You can be mighty proud of it.

But I would not be frank—nor friendly—if I did not add what you know. It is not good enough.

Rome was not doctored in one day. It may be, as some have told me, that the needs of the bulk of our people can be met, given time, through voluntary insurance. What troubles me most are the needs of that sizable segment of society, which does not earn enough to pay for voluntary insurance.

The American Medical Association—its bureau of medical economics—estimated in 1939 that families earning $3,000 or less—two-thirds of the population—cannot afford the cost of serious illness. Some of these can afford voluntary insurance, although inflation has reduced their number. But what of the little fellows who cannot?

I have asked that of nearly everyone with whom I have discussed medical care. Nothing has been suggested so far, which promises success, other than some form of insurance covering these people in by law and financed by the Government at least in part—what some would call "compulsory health insurance."

Since doctors, nurses, technicians and hospitals already are strained, such insurance probably would have to move in stages. That requires careful study. Any program should utilize existing medical facilities to the maximum—it must get started—and be organized to the local level.

Nationally, the program might well be administered by a body of doctors and nondoctors to keep medical care as free from politics as possible.

As to financing, my own preference runs toward the Government meeting only part of the cost, with part coming from payroll deductions from employers and workers. In time, these deductions will become absorbed in general costs of production. I have the utmost confidence in the efficiency of American industry—both labor and management—and which good health will stimulate. We can absorb these medical costs better than other countries which must also meet these needs.

The detailed problems raised by so-called compulsory health insurance are too numerous to be discussed tonight. I have weighed them most carefully. Many doctors and many lay people have sought to paint this issue as a choice—all black or all white. I have found every aspect of medical care to be gray—the happy color sensible compromise wears. All law imposes compulsion. A form of compulsory health insurance for those who cannot pay for voluntary insurance can be devised, adequately safeguarded, without involving what has been termed "socialized medicine." The needs can be met—as in other fields—without the Government taking over medicine, or socializing it, something I would fiercely oppose.

Law protects society. It is the absence of law which destroys it.

I do not fear government taking its legitimate part in medicine, any more than I fear it in education or housing. I do oppose socialization here. It leads ultimately to the police state, degradation of the individual and lessened well-being. There should be just one Federal agency, with Cabinet rank, for all health and human welfare problems. I do not like government agencies to be like Mahomet's coffin, suspended between heaven and earth.

Some say many people do not know how to pick their doctors. So, with any human activity. The best insurance against poor choice is improving the general quality of all doctors. But good or poor, it must be the patient's choice. No one else's.

May I interject this about inflation? Should health schemes fail, be sure to ask—were they killed by the plan itself—by incompetent administration—or by an inflation which ruined the plan's financing?

In connection with this doctor-government relationship, it is a pleasure to point to the excellent medical progress in the Veterans' Administration—thanks primarily to Gen. Omar Bradley and Gen. Paul Hawley. They would never have accomplished their good work, had they not refused to allow the politicos to move in on them.

I would like to see the President name a small committee of top-grade citizens—some doctors, some lay people—to act as a vigilant watchdog over the veterans' medical program, so the ground so arduously gained may not be lost when someone replaces General Bradley. He should be supported by the entire Nation—particularly by doctors. His is the kind of courage and vigilance which will assure good administration of any health program.

More doctors must be distributed to more places in the country, which requires, among other things, less stress on training specialists, more on general practitioners. A number of counties do not even have a doctor. This reflects, in part, a lack of facilities in which doctors can work. Happly, some of this will be corrected under the Hill-Burton Act for hospital construction, with Federal and State governments cooperating.

Orderly change is the American way of life. Remember the spirit of your oath of Hippocrates. Use your own good judgment to move along with humanity's legitimate aspirations in its trek toward better living.

I would hate to see any medical-care program under guidance of other than those who have the know-how. So would the American people. That is why I urge the doctors to get in and pitch—not stand by on the side lines. You need fear politicians or bureaucrats only to the degree you fail yourselves. You must take the leadership—no—yours is now the leadership. Keep it.

This meeting is an outstanding example of your deep concern to meet the need for action.

I have met people in all fields of human endeavor. I respect no group more—for your unselffish zeal and devotion to the sick, for the jealously with which you guard your professional virtue—placing beyond the pale the rare violator of your oath.

I envy you the thrill which comes from relieving a patient from pain, and, often, snatching one from death.

I still am sorry that phrenologist didn't let me become a doctor.

Your situation reminds me of something my father said back in 1873, while president of the South Carolina Medical Society:

"Let us not be silent, but offer our facts, and defend them while we may.

"As an Arabian sage has said,

" 'What good comes from Ali's sword, if it be sheathed?' "

" 'What good from Sadi's tongue, if it be silent?' "

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MAN TO MAN

(By Harold L. Ickes)

In New York last week, that assiduous practitioner of good citizenship, Bernard M. Baruch, wrote a prescription for a much-needed health insurance program for those in low-income groups, and then announced it in an address before 600 leading Manhattan physicians and hospital administrators. Some of them inevitably must have clenched their teeth and refused to swallow what they regard as a nostrum. This was to be expected.

The medical profession is not particularly noted for its liberal social views. But whether the doctors swallowed or gagged, my suggestion to both the New York MDs and to their fellow members of the American Medical Association is that they ponder what Mr. Baruch had to say. The public has not been in the habit of taking the reports of this sagacious man lightly. Even when the medical profession is involved.

As usual, Mr. Baruch had his facts well in hand, and delivered them with the vigor of the young man that he is. "Many doctors," he told his audience, "and many lay people have sought to paint compulsory health insurance as a choice—all black or all white. I have found every aspect of medical care to be grey, the happy color sensible compromise wears. All law imposes compulsion. A form of compulsory heath insurance for those who cannot pay for voluntary insurance can be devised, and adequately safeguarded, without involving what has been termed 'socialized medicine.' The needs can be met, as in other fields, without the Government taking over medicine, something I would fiercely oppose."

Mr. Baruch stated that he had weighed most carefully, during an intense personal study of the whole health program, the "pros" and "cons" of so-called compulsory health insurance. He said that since the number of doctors, nurses and technicians is limited, and hospital facilities already are strained, any program that might be started would have to move in stages, on the local level. Financing, he declared, could be arranged with part of the money coming from employers and employees, and part from the Government. In time he thought pay-roll deductions would become absorbed in the cost of production.

Mr. Baruch called the attention of his audience to the fact that in 1939 the Bureau of Medical Economics of the American Medical Association had estimated that families with an income of $3,000 or less (two-thirds of the population) could not "afford the cost of serious illness." Some of these, he said, can afford voluntary insurance, although inflation has reduced their number. But, in the main, the little fellow cannot.

"I have asked nearly everyone with whom I have discussed medical care about the little fellow," he said. "Nothing has been suggested so far which promises success other than some form of insurance covering these people by law and financed by the Government, at least in part."

The elder statesman of the Roosevelt administration explained that he did not fear "Government taking its legitimate part in medicine," and proposed as one of the 15 points in his compulsory health insurance program, a Federal agency, with cabinet rank, to handle all health and welfare problems. Among his other recommendations were the following: more and better doctors in more places, a prompt survey to modernize medical education, with emphasis on chronic and degenerative diseases, mental hygiene and preventive medicine; more hospitals. more evenly spread through the country.

Fewer specialists; more general practitioners; a reorganization of practice with emphasis on group medicine, where needed, and voluntary health insurance; increased medical research; expanded physical and mental rehabilitation; health education; preventive medical program designed primarily for children; greater numbers of well-trained nurses and technicians; adequate dental care and a stabilizing economy.

The needs for a compulsory health-insurance program in America is compelling. For my part, I can endorse heartily all of Mr. Baruch's recommendations, many of them from my own personal observations. But even if I had to take his plan on faith alone, I would not hesitate. That is how much confidence I have in his integrity and in his ability to solve knotty problems. And I can further assure the medical profession that I need not fear that Mr. Baruch will not listen to its side of the case.

Knowing him as I do, I am confident that he would be anxious to consider any proposed modification of the compulsory health insurance plan that the doctors may suggest. He is a logical man and a just man, although he can also be a firm and persistent advocate. The son of a distinguished doctor, Mr. Baruch, a couple of years ago, made a generous investment of $1,000,000 in medical research in his father's memory.

STATEMENT OF ISIDORE S. FALK, DIRECTOR, BUREAU OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION, WASHINGTON, D. C., ACCOMPANIED BY WILBUR J. COHEN, ASSISTANT DIRECTOR, BUREAU OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION

Mr. Falk. Mr. Chairman, may I interrupt before we proceed? May I have the privilege of offering to the committee a document which bears on some matters which were under discussion when I was testifying before the committee on July 23, and which I would like to offer, with your permission, for the record?

At the hearings on July 23, Senator Donnell asked me many questions, and he explored at considerable length an item concerning whether or not, when I left the employ of the Chicago Department of Health I had resigned or had been dismissed at the time the new commissioner of health was appointed, replacing the former commissioner, and the new commissioner announced he intended to dispossess from the staff a number of persons who had been there under the tenure of his predecessor. I was not able, you may recall, to remember nor to present conclusive documents at the time as to just what transpired.

After those hearings in July I wrote a letter to Dr. Bundesen, the present commissioner of health in Chicago and asked him to furnish me with the facts, if they were available to him from his records. I received a reply from him dated September 2, 1947, which I would like to offer for the record, if I may, Mr. Chairman.

Senator SMITH. It will be received.

Senator DONNELL. May I see it? I have no objection to it at all, but I would like to see it.

(Mr. Falk handed the letter to Senator Donnell.)

Mr. FALK. Might I say that with respect to my employment in the Chicago Health Department, he gives the dates and positions to which I had been appointed, and says that I served in the last position which he mentions until January 1, 1928, "on which date you resigned." Then he says [reading]:

> We have been unable to locate your letter of resignation since such communications are not kept for longer than a 5-year period.
>
> You may be sure that I am willing to go on record that your work was always satisfactory; that you were always accurate, and certainly at no time could any statement be made that you misinterpreted statistical data.

Senator DONNELL. I have no objection to this going into the record.

Senator SMITH. Are you putting in the original or a copy?

Mr. FALK. I will offer the copy for the record, if that is satisfactory.

Senator SMITH. Yes, that is satisfactory.

(The copy of the letter referred to follows:)

BOARD OF HEALTH,
OFFICE OF THE PRESIDENT,
City of Chicago, September 2, 1947.

Dr. I. S. FALK,
Chevy Chase, Md.

DEAR DR. FALK: I have delayed answering your letter since I have been trying to get what information I could to aid you in the problem with which you are confronted.

According to the records available in the Chicago Health Department at this time, you served as director of surveys from January 1, 1926, to June 2, 1926, at which time you were appointed assistant director of the bureau of child welfare. On May 20, 1927, you were again appointed director of surveys and you served in this position until January 1, 1928, on which date you resigned.

We have been unable to locate your letter of resignation since such communications are not kept for longer than a 5-year period.

You may be sure that I am willing to go on record that your work was always satisfactory; that you were always accurate, and certainly at no time could any statement be made that you misinterpreted statistical data.

Hoping that this information will be of some service to you, and trusting I shall see you at the APHA meeting, I am, with kindest personal regards

Very truly yours,

HERMAN N. BUNDESEN,
President, Board of Health.

Senator DONNELL. Mr. Falk, we have before us at this time the two bills, S. 1320 and S. 545. I would like to go back a little into the genealogy of S. 1320. Am I correct in stating that the first of the series of bills which were submitted by Senator Wagner, either by himself or by others, was the one submitted in 1939, namely, S. 1620?

Mr. FALK. I believe you are correct, sir.

Senator DONNELL. And that is the bill concerning which I interrogated you at page 3418 of the mimeographed copy as follows [reading]:

> Senator DONNELL. Did you and your staff in 1939 prepare or assist in preparing the draft of the first Wagner bill, S. 1620?
>
> Mr. FALK. I participated in the preparation of the draft as a member of the interdepartmental committee. My staff, I believe, participated in the preparation of one title of that bill. I am not sure whether their participation extended beyond one title of that bill or not.
>
> Senator DONNELL. Do you remember what title that was?
>
> Mr. FALK. I will not trust my memory, Senator. I will ascertain it.

> Senator DONNELL. Just to refresh your memory was it title 13, grants to States for medical care?
> Mr. FALK. That sounds correct, Senator. I can verify it.
> Senator DONNELL. Would you recognize it if you were to see it? I have a copy here; page 34.
> Mr. FALK. Looking at it now, I would say I am sure some members of my staff assisted in the preparation of the drafts which were eventually utilized by the interdepartmental committee for preparation of title 13, and I would also guess, though I have no sure recollection of this, that members of our staff participated in preparation of underlying material which was used by the interdepartmental committee with respect to title 14.

Do you recall that testimony, Mr. Falk?

Mr. FALK. Yes, sir. What page did you say?

Senator DONNELL. Beginning at page 3418. The concluding paragraph from which I just read is [reading]:

> I do remember Mrs. Shearon and others were among those who did a large part of the underlying work.

May I say at this point, Senator Smith, that Dr. Shearon, who sits at my right, is here with me this morning at my request, to assist me in connection with the work of this committee.

So that we start then, Mr. Falk, as I see it, with the 1939 Wagner health bill. Now, what was the next bill that was introduced by either Senator Wagner or by himself and others?

Mr. FALK. I presume you have reference, Senator, to the health bills in this series?

Senator DONNELL. May I ask you if it was S. 1161, which was introduced by Senator Wagner for himself and Mr. Murray on June 3, 1943?

Mr. FALK. I think not, Senator. If you will permit me a moment, I will get my notes. I think the next bill was a bill on a proposal with respect to grants for the construction of hospitals. Yes, I think I am right, Senator, that the next bill, the next health bill, introduced by Senator Wagner was S. 3230, introduced on February 1, 1940, by Senator Wagner and Senator George.

Senator DONNELL. That was by Senator Wagner and Senator George?

Mr. FALK. Yes, sir.

Senator DONNELL. That was a hospital bill?

Mr. FALK. Yes, sir.

Senator DONNELL. That had nothing about health insurance in it, did it?

Mr. FALK. I think it did not, except insofar as, of course, the construction of hospitals in places where there is need for additional facilities is essential to any comprehensive health insurance program.

Senator DONNELL. Regardless of the fact that hospitals do have a bearing on health, of course, S. 3230 had nothing to do with a plan of compulsory health insurance. That is correct, is it not?

Mr. FALK. No, sir; in a sense the construction of hospitals is an essential and integral part of any program for compulsory health insurance for any considerable number of people, in that it is an element in the program to provide the facilities necessary for a health program.

Senator DONNELL. That is, S. 3230 made provision for hospitals to be constructed from public funds? Is that right?

Mr. Falk. For grants-in-aid for the construction of hospitals with public funds. I hesitate a moment to say whether it was restricted to public funds. I am not sure that it was.

Senator Donnell. Very well. That bill, however, had nothing to do with the collection of taxes or the securing of funds with which to pay physicians for services in the performance of medical services for patients?

Mr. Falk. Not directly. Indirectly it would.

Senator Donnell. We will not quarrel over that particular bill. That was a hospital bill. That is correct, is it not?

Mr. Falk. A hospital construction bill.

Senator Donnell. A hospital construction bill. Now, the next bill along the line of the 1939 bill, namely, S. 1620, was S. 1161, was it not, which was introduced, as I have indicated, June 3, 1943, by Mr. Wagner for himself and Mr. Murray?

Mr. Falk. No, sir; there was another bill.

Senator Donnell. What was the other one?

Mr. Falk. A bill on the permanent disability aspect of the subject. That was Senator Wagner's bill, S. 3924, which was introduced on May 6, 1940.

Senator Donnell. What was that bill about, did you say?

Mr. Falk. On the method of providing benefits for the disabled.

Senator Donnell. Providing benefits for the disabled. Now, was there any other bill which was filed by Mr. Wagner for himself and others between S. 3924 and S. 1161?

Mr. Falk. I think not, Senator. I think S. 1161 was next.

Senator Murray. There was a bill filed by Senator Capper, S. 489, on January 23, 1941, to establish an administration of State health insurance plans.

Senator Donnell. What date did you say that was, Senator Murray?

Senator Murray. January 23, 1941.

Senator Donnell. Was Senator Wagner one of the sponsors of that bill?

Senator Murray. No, he was not.

Senator Donnell. You were not either?

Senator Murray. No, that was a bill by Senator Capper alone.

Senator Donnell. That was S. 489.

Mr. Falk. May I interrupt to say that I understood your question, Senator Donnell, to be first as to bills introduced by Senator Wagner?

Senator Donnell. Yes.

Mr. Falk. Of course, there were bills by other members of the Congress.

Senator Donnell. What I was trying to do is to trace down the proposed legislation introduced by Senator Wagner or Senator Murray, or both of them, along the lines of health insurance, and as I understand it, the next bill which was presented by Senator Wagner after those that you have referred to was S. 1161, introduced June 3, 1943, for himself and Mr. Murray, that is correct, is it not?

Mr. Falk. I think that is correct.

Senator Donnell. Will you please state what, if any, services you rendered, or your staff rendered, in the preparation of S. 1161?

Mr. Falk. Yes, Senator; I will be glad to. S. 1161 was a large, comprehensive bill dealing with the very broad field of social security generally, and our services to Senator Wagner and Senator Murray had been on the background material. It is my recollection that the work done in the Social Security Board which resulted in the preparation of the material that was made available to the members of Congress, on their request, goes back, of course, quite a long way, quite a long while before the year in which that bill was introduced. I would not want to take the time of the committee to try to recall the whole detailed story, because the work was done in the Social Security Board over a long period, and that material was utilized by the members of Congress in that bill. That work has been going on for something close to a decade. The Board members themselves as a unit, and all bureaus of the Board, had been more or less constantly engaged in studying the operations of the Social Security Act, devising and developing improved and new methods of providing social security for the people of the United States. Consequently, in the course of those years, while those studies were going on in the Social Security Board, a great deal of work was done in the development of methods, of devices or proposals for the revision of the existing Social Security Act, its extension, the formulation of new proposals, their correlation or coordination or integration with existing measures.

In the course of that work there were built up in the offices of the Social Security Board files containing the knowledge and skills and understandings of the staff, with a great many proposals, developments, devices, written out in extensive documents in brief memoranda, and in draft language. All of these are methods constantly used for thinking through the proposals that we have developed. As I said a little while ago, that was going on throughout the Social Security Board organization.

In the Bureau of Old-Age and Survivors Insurance, for example, a great deal of such work was going on with respect to old-age and survivors insurance and the development of certain disability insurance benefits.

In the Bureau of Unemployment Compensation, later the Bureau of Employment Security when its name was changed, similar work was going on in respect to unemployment insurance, employment services, temporary disability compensation, and related matters.

In the Bureau of Public Assistance similar work was going on with respect to the three existing public assistance programs, the proposals with respect to Federal aid for general assistance and related assistance and welfare matters.

The same sort of thing was going on in the Bureau of Research and Statistics with respect to all of the programs that I have mentioned, with respect to interrelated problems, with respect to the over-all program matters, and with respect to areas which were specifically within the special field of the Bureau of Research and Statistics, on such matters as the health and disability field, the over-all financial field, and similar matters; consequently, the Security Board organizations have dealt with many documents of many kinds dealing with many proposals. Shortly after, in 1939——

Senator Donnell. What I wanted you particularly to direct your attention to was the specific question as to whether or not you and your staff assisted in drawing S. 1161, the 1943 document. Did you?

Mr. FALK. That is what I am directing my remarks to, Senator.

Senator DONNELL. You, of course, are going back to 1939. We have already had the 1939 bill before us. Now I wanted to ask you whether or not you and your staff assisted in the preparation of 1161. Did you?

Mr. FALK. Senator, perhaps I am being misunderstood. The 1939 bill—I am trying to tell you what we did develop in the bill you have reference to.

Senator DONNELL. Would you mind for the moment confining yourself to the specific question that I now address to you, namely, did you and your staff assist in the preparation of S. 1161, the 1943 bill?

Mr. FALK. It is a little hard for me to answer that yes or no because we assisted, we among many others assisted, in the development of material which was utilized by the Senators in their development of what became S. 1161.

Senator DONNELL. Well, did you personally or through your staff assist in the preparation of that portion of S. 1161 which appears at page 39, namely, Federal Medical Hospitalization and Related Benefits?

Did you assist, without going into the details and all the various ramifications of it?

Mr. FALK. Did you say, Did we assist him?

Senator DONNELL. Did you assist in the preparation of that portion of the bill which is set forth at page 39 and following and is an amendment of title 9 of the Social Security Act reading as follows: "Federal Medical Hospitalization and Related Benefits."

Mr. FALK. Yes, sir; we assisted. We did a good deal of work in the development of material which was later utilized by the Senators in that part of the bill.

Senator DONNELL. Did you or your staff assist in the drafting of that portion of the bill?

Mr. FALK. Yes, sir; we did.

Senator DONNELL. Now do you recall, Mr. Falk, that late in 1943, which was the year in which S. 1161 was introduced into the Senate, that Dr. Michael Davis organized the health program conference? Do you remember that, whether he organized it, that it was organized and that he participated in its organization? Do you remember that?

Mr. FALK. I remember that he organized a health program conference. I didn't understand the relationship of the latter part of your question to the first part.

Senator DONNELL. Do you remember that in 1943 the health program conference was organized?

Mr. FALK. Yes, sir.

Senator DONNELL. And did Mr. Michael Davis have anything to do with the organization of it, to your knowledge?

Mr. FALK. Yes, sir; to my knowledge he was primarily responsible for organizing it.

Senator DONNELL. And you were among the gentlemen who were in that conference, is that right?

Mr. FALK. Yes, sir.

Senator DONNELL. Among the 29 persons I think named in the booklet entitled, Principles of a Nation-wide Health Program, Report of the Health Program Conference, that is right, isn't it?

Mr. Falk. Yes, sir.

Senator Donnell. This report to which I have directed your attention, namely, Principles of a Nation-wide Health Program, was published under the auspices of the Committee on Research in Medical Economics of which Mr. Michael Davis was chairman, that is correct, is it not, as shown on the front fly, I believe?

Mr. Falk. What do you mean by, "under the auspices of," Senator?

Senator Donnell. Well, did the Committee on Research in Medical Economics cause to be published or cooperate in the publication of this pamphlet entitled, Principles of a Nation-wide Health Program?

Mr. Falk. It was published with the cooperation of the Committee on Research in Medical Economics.

Senator Donnell. And that was in November 1944, was it not?

Mr. Falk. Yes, sir.

Senator Donnell. Now the next bill in order of sequence which was introduced by Senator Wagner for himself and others was S. 1050, was it not, which was introduced on May 24, 1945, is that right?

Mr. Falk. I think that was the next bill with which Senator Wagner's name was connected in the health field.

Senator Donnell. Yes.

Mr. Falk. Yes.

Senator Donnell. Each of these bills, that is to say, S. 1161 and S. 1050 contained provisions for financing of the proposed program, did it not?

Mr. Falk. Yes, sir.

Senator Donnell. And each of these bills was referred to the Committee on Finance in the Senate, was it not?

Mr. Falk. Yes, sir.

Senator Donnell. Did you or your staff assist in the preparation of S. 1050?

Mr. Falk. Yes, sir; we did, in the preparation of S. 1050.

Senator Donnell. Did you personally assist in the preparation of S. 1050?

Mr. Falk. Yes, sir; I did.

Senator Donnell. Now the next bill in order of sequence presented by Mr. Wagner for himself—for himself and anyone else—was S. 1606 in November 1945, by Mr. Wagner for himself and Mr. Murray, was it not?

Mr. Falk. Yes, sir; I think it was.

Senator Donnell. This bill S. 1606 eliminated or failed to contain any provisions as to the financing of the proposed program, did it not?

Mr. Falk. Yes, sir; and it also eliminated almost everything else in the whole social-security field other than what dealt with health.

Senator Donnell. This act, S. 1606, was entitled, "The National Health Act of 1945"; that is correct, is it not?

Mr. Falk. I presume so, if you have it there, Senator.

Senator Donnell. I have it right here and just read it. That bill was referred to the Committee on Education and Labor, was it not?

Mr. Falk. Yes, sir.

Senator Donnell. And as you know, Senator Murray was the chairman of that committee; that is correct, isn't it?

Mr. Falk. Yes, sir.

Senator Donnell. Did you know whether or not the Committee on Finance made any report with respect to either S. 1161 or S. 1050?

Mr. FALK. I don't think it did.

Senator DONNELL. And do you know whether any hearings were held by the Committee on Finance on either of those two bills?

Mr. FALK. I don't believe there were any.

Senator DONNELL. Do you know whether the primary reason for the introduction of S. 1606 was to provide a bill which would not contain the financial provisions, thereby making it not proper to introduce the new bill S. 1606 for reference to the Committee on Finance, but was a bill which would naturally go to the Committee on Education and Labor? Do you know whether or not those facts were largely if not entirely responsible for the preparation of S. 1606?

Mr. FALK. To the best of my knowledge they were not primarily responsible for that.

Senator DONNELL. Were they in any part responsible for the preparation of S. 1606, if you know?

Mr. FALK. I don't know that. I do know the primary reason of which I have knowledge why the health provisions were split off at that time, I think that was November 1945, from the large social-security bill, was because Senator Wagner, Senator Murray, and Mr. Dingell reached an agreement with the President of the United States that at the time when the President of the United States was planning to send a special message on health to the United States Congress, at that time they, the sponsors of that legislation, would introduce the health parts of their social-security bill as a separate bill.

Senator DONNELL. Now that message of the President to which you refer is the message of November 19, 1945, Document No. 380, Seventy-ninth Congress, first session, is that correct?

Mr. FALK. Yes, sir.

Senator DONNELL. Did you have anything to do with the preparation of any portion of that message?

Mr. FALK. Yes, sir; I did.

Senator DONNELL. Do you mind telling us just what part you took in the preparation of that message of the President?

Mr. FALK. Not at all. I will give it to you in brief and without trying to remember dates or precise details. I will be glad to tell you further about it.

In brief, as of some particular date, I remember being informed by the Chairman of the Social Security Board that the White House had in preparation a message on health and that the assistance of the Social Security Board had been requested by the White House, and that of course the Chairman of the Board had assured the White House that it would give all assistance that was desired.

At some point a draft of a message was made available to us for review, for comment, and criticism.

Senator DONNELL. By whom was it so made?

Mr. FALK. By the White House, and it came to me from the Chairman of the Social Security Board with the request that I review it, comment, and criticize it and make any suggestions that I thought were indicated. I did so, and was very happy to do so and very greatly pleased at the honor of doing it.

Senator DONNELL. May I call your attention to this language appearing on pages 9 and 10 of that message of the President, and I quote:

> The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have mis-

named it "socialized medicine." I repeat what I am recommending is not socialized medicine. Socialized medicine means that all doctors work as employees of Government. The American people want no such system. No such system is here proposed.

Under the plan I suggest our people would continue to get medical and hospital services just as they do now, on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with the same professional freedom as now. There would, however, be this all-important difference, whether or not patients get the services they need would not depend on how much they can afford to pay at the time

Would you state, please, whether you had any part in the preparation of that portion of the message which I just read?

Mr. Falk. I am sorry, Senator, I wouldn't know that. I couldn't assume responsibility for any particular language in that message since my contributions were fragmentary and partial. I was only one among possibly many persons whose contributions to that message were utilized by the White House and I would have no knowledge whatever at this time as to whether I had any personal responsibility for any particular paragraph or sentence or phrase or word.

Senator Donnell. Do you have any recollection as to whether or not this point to the effect that the health insurance is not socialized medicine was in the message when the message draft came first to you?

Mr. Falk. I do not know that, Senator.

Senator Donnell. You do not know?

Mr. Falk. No, sir.

Senator Donnell. You are not certain whether it was in there or not, is that right?

Mr. Falk. Quite so.

Senator Donnell. I will introduce into the record at this time, Mr. Chairman——

Mr. Falk. I would be glad to say, Mr. Chairman, if this is in response to your question, that at no time so far as I am aware of, have I ever been responsible for using any sentence or long phrase that includes the phrase, "socialized medicine," unless I was using it only to point out that that phrase is not meaningful, is not clear, but on the contrary is greatly misunderstood, ambiguous and doesn't contribute very much to understanding the field.

In other words, I don't use that phrase except when I wish to point out what I think it is or is not, and in order to clarify what the phrase may mean or may not mean.

Senator Donnell. You do not consider that the term "socialized medicine" is a misnomer as applied to the health insurance projected by the bill which we now have before us and projected by S. 1606?

Mr. Falk. Senator, I have long been confused by that phrase ever since Dr. Fishbein first used it in that connection, and I am still more confused now that the Journal of the American Medical Association has given it a new meaning in a formally published definition of the term.

They have recently defined it in such a way that it embraces not only compulsory health insurance but voluntary health insurance, specifically even the voluntary prepayment plans that are sponsored by the American Medical Association and by State and local medical societies.

Senator Donnell. I may ask you specifically whether you concur with this sentence in the President's message which I have read. "They—" that is to say, the American people, "—will not be frightened off from health insurance because some people have misnamed it socialized medicine." Do you concur in that statement?

Mr. FALK. Yes; I do.

Senator DONNELL. Do you concur in the next statement? "I repeat what I am recommending is not socialized medicine."

Mr. FALK. I would say to the best of my understanding as to what that sentence means in the context, I do concur.

Senator DONNELL. Do you concur as of 1945 in that sentence, understanding socialized medicine to mean what you understood it generally to be deemed at that time?

Mr. FALK. I am sorry, I didn't understand the question.

Senator DONNELL. The question is this. Do you concur that when the President said, "I repeat, what I am recommending is not socialized medicine," do you concur in the correctness of that statement, considering socialized medicine to mean what you then understood it to mean?

Mr. FALK. In this context, yes.

Senator DONNELL. All right, and do you concur also in this next sentence of the President's message?

"Socialized medicine means that all doctors work as employees of government." Do you concur in that?

Mr. FALK. I concur in that in this context; yes, sir.

Senator DONNELL. So there is no portion of what I have read to you, I take it, from the President's message, in which you failed to give your concurrence; is that right?

Mr. FALK. Yes, sir; stated in its context.

Senator DONNELL. Very well, stated in its context in the message.

Referring now again to S. 1606, did you or your staff assist in the preparation of that bill, S. 1606?

Mr. FALK. We assisted members of the United States Congress, upon their request, in the preparation of that bill; yes, sir.

Senator DONNELL. Do you know whether or not you personally wrote any portion of that bill or did you simply have your staff prepare the portions in line with your thoughts?

Mr. FALK. I don't know at this time, Senator.

Senator DONNELL. You are familiar with the testimony of Mr. Altmeyer as to your participation in this particular bill, are you not?

Mr. FALK. Yes, sir.

Senator DONNELL. Now the next bill in order as presented by either Senator Wagner or Senator Murray was S. 1320, the bill now before us; is that correct?

Mr. FALK. I think so; yes, Senator.

Senator DONNELL. And would you state whether or not you and your staff or either you or your staff assisted in the preparation of that bill?

Mr. FALK. Concerning the revision of S. 1606 into S. 1320, I have a brief memorandum which was prepared for Mr. Watson B. Miller, at that time the Federal Security Administrator, at his direction and by his office, preparatory for his testimony when he appeared before this committee on July 9. He did not use that memorandum. As I recall, there was no occasion for him to do so; but his office furnished me with a copy of it and gave me permission to use it, so if I may, Senator, I would answer your question by reading this very brief statement of the Administrator's.

Senator DONNELL. Very well.

Mr. FALK. This is a memorandum on the drafting of S. 1320 and he said [reading]:

> At the request of the chairman of the Senate Committee on Education and Labor of the Seventy-ninth Congress—

Senator Murray he was referring to—

> the Federal Security Agency studied the hearings and public discussions on S. 1606 and submitted to the chairman a set of proposals for the consideration of the sponsors of that legislation.
>
> On August 7, 1946, Senator Murray, chairman of the Senate Committee on Education and Labor wrote to me, in part, as follows:
>
> "I should greatly appreciate it if you can appoint someone from your office, as well as a representative of each of the major bureaus within the Federal Security Agency, to meet with Mr. ——— during the next few months for the purpose of drafting a final set of proposals which can be submitted to the sponsors of this legislation."
>
> On October 1, 1946, Senator Murray wrote to me again, in part, as follows:
>
> "I should like to suggest that the Federal Security Agency review the record carefully and submit to me and the other sponsors a redrafted bill, together with any alternative drafts or suggestions on questions which may be of such kind as only the sponsors can resolve. It is my hope that a proposed redraft can be submitted to me for review by all the sponsors no later than the end of the first week in December, so that we will have sufficient time to study it carefully."
>
> On October 23, I wrote the Chairman advising him that I had set up an intra-agency committee of the character he had requested.
>
> On December 30, 1946, I submitted to Chairman Murray the major portion of the draft he had requested. I might add, in passing, that the sponsors changed the draft in certain significant respects. In submitting this redraft, I said to Chairman Murray:
>
> "You know, of course, that I am always ready to be of whatever help possible to your good self and to your colleagues."

And he then said [reading]:

> That, Mr. Chairman, is the point of this whole narration: The Federal Security Agency is always ready to assist any committee of Congress, upon request. This is very similar to what we have done on many bills, such as for example, the Hospital Survey and Construction Act, in which the Agency has made personnel available, upon request, to assist in the drafting or redrafting of legislation in the fields of our official concern. It is what we would be very happy to do if this committee should ask our advice and technical assistance.
>
> I might also add that detailed and continuous study of social security and health insurance is an obligation of the Federal Security Agency under section 702 of the Social Security Act, which reads:
>
> "The board shall perform the duties imposed upon it by this act and shall also have the duty of studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation and related subjects."
>
> I trust, therefore, that answers Senator Donnell's question as to participation within the Federal Security Agency in assisting the chairman of the Senate Committee on Education and Labor on his request in the redrafting of S. 1606 and the subsequent utilization in a bill which Senator Murray and Senator Wagner introduced and which became S. 1320.

Senator DONNELL. Mr. Falk, in our examination last July reference was made to your connection with the Committee on the Costs of Medical Care between 1929 and 1933. Had you prior to that time, that is prior to the date on which you became associate director of that committee, published any articles or letters or any other communications on the subject of health insurance?

Mr. FALK. Prior to 1929?

Senator DONNELL. Yes, sir.

Mr. FALK. I think I did, sir. I think I wrote one article on that subject many years before. I wouldn't remember the date, and there might have been others.

Senator Donnell. Do you recall where that article which you wrote many years before 1929 was published?

Senator Smith. Senator Donnell, Senator Murray had to go away for a short time, and I proposed recessing until he could return, but he asked us to go ahead with the examination. Some of his aides are here and will keep track of what transpires, for him. We expect Senator Pepper here in a few minutes, so he will take up where Senator Murray left off.

(The reporter read back the last question.)

Mr. Falk. I am sorry, but I don't, Senator.

Senator Donnell. Was it published, do you remember, Mr. Falk, or was that an article which you wrote for some purpose in the course of your educational work, preliminary article to graduation?

Mr. Falk. I don't remember its relation to graduation. I have only a vague recollection that about the time when the health-insurance subject was being extensively debated, which would be somewhere about the period 1918 to '22 or '23, somewhere in there, that I read on that subject and wrote a little paper largely based on the writings of Prof. Irving Fisher and Mr. John Andrews, Professor Chamberlain, and others who were very active in that field.

I don't recall the specific occasion for which it was done. There apparently was one. And that it came to the attention of some of the people interested in the subject; and with my permission, I presume, it was published. But I don't recall where.

Senator Donnell. Do you recall the general thesis of your paper to which you refer, what you indicated therein?

Mr. Falk. I only recall that it was in general in accord with the proposals of what was then called health insurance as sponsored, if I remember correctly, by the American Association for Labor Legislation and its associates and friends. I don't remember the details.

Senator Donnell. Was that a plan under which there was to be a grant in aid to the States, or was it a plan for Federal insurance?

Mr. Falk. I don't remember specifically, but my guess would be, Senator, it would be plans for State legislation alone. It would be either a Federal proposal, that is a proposal for Federal legislation, or Federal grants-in-aid.

Senator Donnell. You are not able to give us approximately the date on which that first article appeared?

Mr. Falk. Not more than to narrow it within the period 1918 or '19 to 1925 or '26; somewhere in there, I would guess. If I am recalling it correctly, it was something written about the time when that subject was receiving very extensive consideration in many States in this country.

Senator Donnell. You have no recollection at all as to where that was first?

Mr. Falk. I am sorry, Senator, but I don't.

Senator Donnell. All right. Do you recall the next article which you caused to be published relating to the subject of health insurance?

Mr. Falk. I don't remember what next article I may have written. When you say "caused to be published" I would expect under the latter phrase it would be one or another of the publications of the Committee on the Costs of Medical Care and dealing not so much specifically with health insurance as with matters concerning the general situation in the health field, needs for health care, facilities, practices, voluntary insurance plans, et cetera. I wouldn't remember just what the next one was, though.

Senator DONNELL. Well, suppose we proceed now to 1934. Do you remember an article which you caused to be published, or which you prepared for publication, in the American Association for Labor Legislation Review of June 1934 entitled, "Formulating An American Plan of Health Insurance?"

Mr. FALK. I remember generally there was such an article. It would be my recollection it was published in the magazine issued by the American Association for Labor Legislation.

Senator DONNELL. I would like to have this incorporated in the record, Mr. Chairman, at this point.

Senator SMITH. No objection.

(The article referred to is as follows:)

[From American Association for Labor Legislation Review, June 1934]

FORMULATING AN AMERICAN PLAN OF HEALTH INSURANCE

By I. S. Falk

EDITOR'S NOTE.—Health insurance has been given increased attention in recent issues of this Review; and at the Annual Meeting of the American Association for Labor Legislation at Philadelphia in December and at its mid-year meeting at Kansas City in May, it was discussed at several of the sessions. The association's committee has been working on the subject during the past year and its recent conferences indicate favorable prospects for a new effort for this legislation throughout the country. Dr. Falk, Research Associate of the Milbank Memorial Fund, in this article written especially for the Review, gives a helpful discussion of the chief questions involved in the preparation of the needed legislation.

Neither the rich nor the poor, nor the great middle classes of the American people receive anything like adequate medical care. This is true in good times; it is only more lamentably true in bad times. Among people in the highest income classes, indifference, ignorance, apathy and similar causes are responsible. Among the well-to-do, the comfortable, and the poor the principal reasons are of another kind. Among these classes it is not that there is inadequate demand for the service or an insufficient supply of medical practitioners or institutions to furnish it. The people want and the professions are equipped to supply vastly more and better medical care than is now provided. An economic barrier stands between the two. How shall it be surmounted?

At the outset, let us be clear on the nature of the problem. The objective is more and better medical care for everyone. The principal questions are these:

(1) How shall people be enabled to purchase the medical care which they need?

(2) How shall practitioners be assured a decent income?

(3) How shall hospitals and other institutions be assured adequate financial support?

(4) How shall the quality of medical care be maintained on a high level?

The costs of medical care[1] are burdensome more because they are variable, uncertain, and unbudgetable for the individual family than because they are high. To be sure, a substantial part of the population is without means and cannot pay for any necessities of life. Another fraction is not indigent, but neither is it entirely self-sustaining; and people in this class require some assistance if they are to receive good medical care. Above these indigent and semi-indigent groups, the rest of the population is self-sustaining and can afford the costs of adequate health and medical service for themselves and the subventions for the poorer classes, if they can pay these costs as a group.

Taken as a single unit, the people of the United States can support a program of adequate care for everyone. Indeed, we ordinarily spend almost enough to meet all requirements. As against a normal expenditure of $30 per capita, $36 would provide adequate service for the population of the country. But purchased privately and individually, even in the best of times, medical service is in greater or lesser degree beyond the means of 75 to 90 per cent of the population.

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[1] For a comprehensive analysis of the subject see the Costs of Medical Care, by I. S. Falk, C. R. Rorem, and M. D. Ring (University of Chicago Press, Chicago, 1933).

It is therefore not surprising that we turn at once to the insurance principle for a solution to the basic problem of medical costs. We seek an appropriate means of substituting an average for an individual cost of medical care. The insurance principle has been applied to so many types of financial risk, especially in the United States, that no element of novelty can be claimed for the proposal. In some forty countries of the world, the principle has already been applied on a national scale to the risk of incurring the financial consequences of sickness. It has been similarly applied in the United States in hundreds of communities where voluntary organizations have developed the group budgeting of medical costs.

Insurance against medical costs would substitute the predictable average cost of the group for the uncertain and highly variable costs of individuals. More than this, insurance would enable people to spend more than they now spend for medical care. If present expenditures for medical care were made in quarterly, monthly or weekly installments throughout the year, people could pay what they now spend for medical care, and more, with much less difficulty than they experience at the present time. Insurance would bring within their means more and better care than they now secure and would provide more substantial and more stable incomes to practitioners and institutions. Under a system of fixed, periodic payments, complaint about the high costs of medical care would disappear; for the public protest against medical costs rests upon experiences with the catastrophic consequences of the occasional expensive illness. This is the reason why the average costs of medical care furnish no explanation of public discontent with the high costs of medical care.

II

A fortunate characteristic of an insurance proposal to meet the public need is that simultaneously it solves the problem of the physician's and the hospital's income. If group budgeting and fixed periodic payment will enable people to spend more for medical care, by the same token it provides larger and more certain incomes for those who furnish the service. This is an important characteristic of an insurance proposal, because a solution is as acutely needed for the economic problems of the practitioner as for the straits of the public.

In a certain sense, it is true that there is nothing new in a proposal for insurance against the costs of medical care. Health or sickness insurance is an old story in almost all European countries; numerous voluntary plans have had a long history in the United States; and in the years 1912–20 an active campaign was carried on in this country to enact health-insurance legislation in the Federal Congress and in the several States.

In another sense, insurance against medical costs is a new story in the United States. Between 1927 and 1932, the Committee on the Costs of Medical Care conducted a careful study of the entire problem and through the inquiries reported by its research staff developed exact, quantitative information on almost every important phase of the subject. These studies brought together a mass of information such as no country of the world has possessed. Furthermore, the economic depression has brought a National awakening on the need for social insurance and a recognition that illness is one of the principal hazards of life against which society must give the individual protection and assurance.

Not only the public, but even the medical professions have become acutely aware of the need for insurance against the financial consequences of illness. Despite a *laissez faire* attitude on the part of the American Medical Association or even covert opposition and obstruction, the American Hospital Association has formally approved the principle of insurance against hospital costs and is cooperating effectively with local groups engaged in creating or operating hospital insurance plans. At least five State medical societies—California, Oregon, Washington, Michigan, and Colorado—have in one form or other recorded their approval of insurance against medical costs, and a sixth—New Jersey—has expressed a constructive attitude toward experiments in this direction. Indeed, in the first three States, practical programs have been going forward under medical direction and leadership. The Medical Society of the State of New York has endorsed the principle of group budgeting of hospital costs.

Health insurance therefore has an entirely new opportunity; and there is a more substantial basis for its formulation than existed before. The creation by the American Association for Labor Legislation of a National Committee for Health Insurance Legislation is timely and appropriate.

We pride ourselves that we are practical folk. Hence, as we approach the task of formulating a program, let us be practical and build upon the experiences of voluntary groups in the United States and of national systems in other countries. If we must be original and nationalistic, and if we must have an American plan, let it be compounded from the best we can adapt from European systems and the best we can devise to meet the peculiar characteristics of American needs.

III

How shall we formulate an American plan? First we might enumerate the objectives:

(1) Provision of good health service and medical care to all persons in the population.

(2) Distribution of the costs over groups of people and over periods of time.

(3) Adequate remuneration of those who furnish medical care.

(4) Flexibility in the scope of medical benefits so as to permit adaptation to local variations in available personnel and facilities.

(5) Exclusion of proprietary or profit-making agencies.

(6) Coordination with other health, medical or welfare activities of the community.

(7) An adequate program of public education on the need and the opportunity for medical care.

Second, it is important to keep in mind some practical lessons which emerge from an analysis of European and American experience with health insurance:

(1) Freedom of all competent practitioners who subscribe to necessary rules of procedure to engage in insurance practice.

(2) Freedom of all persons to choose their physician or dentist from among all practitioners in the community who engage in insurance practice.

(3) Freedom of insurance practitioners to accept or reject patients.

(4) Minimum interference of the insurance system with the private practice of medicine for those who prefer and can afford the private purchase of medical service.

(5) Professional control of professional personnel and procedures.

With these before us, we may consider more specifically the questions which should engage the attention of a national committee devoted to the task of formulating specific health insurance legislation. By the very task of dividing the major problem into many smaller ones, we clarify and bring into sharper relief the issues which are at stake.

IV

1. *Which portion of the population should be included in the plan?*

Should the program be restricted, as in some countries, to those who earn less than a specified income, or should the system apply to the small wage–earners and their dependents? Should an American Plan be restricted to the lowest economic classes and perpetuate the traditions and the shortcomings of a poor–man's system? Or should the plan embrace all economic groups in the population to whom the private purchase of medical care brings variable costs which are burdensome and which cannot be budgeted on an individual or family basis? Or, finally, should the plan include entire populations?

2. *Should health insurance be founded on a voluntary or on a compulsory basis?*

There is room for wide difference of opinion on this score. European experience shows that every voluntary plan is merely a longer or shorter bridge to a compulsory scheme. Can those who most need the benefits of health insurance be brought within its scope on a voluntary basis, or must the plan be compulsory in order that they may be covered? Have we the machinery, equivalent to the friendly or insurance societies of European countries, with which to administer voluntary insurance? Or, lacking this, should we create *ad hoc* administrative agencies? Or would it be wiser to avoid the administrative problems incidental to the requirements of voluntary agencies and move at once to the compulsory stage?

3. *Shall we have cash benefits in addition to medical care provided by the insurance plan?*

Health or sickness insurance had its origin in trade guild or mutual benefit associations, originally concerned with establishing a pool from which the disabled worker might receive partial remuneration for wages lost in time of sickness. Increasingly, however, benefit in kind—that is, medical care—has been substituted for cash benefit. Restoration rather than compensation has become prominent in the purposes of health insurance. The administration of medical benefit is undoubtedly made vastly more complex by the simultaneous provision of cash benefit. The dual function of furnishing care and of certifying disability—and hence eligibility to cash benefit—creates serious difficulties in the smooth and economical administration of health insurance. Should the two types of benefits be nonetheless included in the American plan?

4. What shall be the scope of medical service furnished under the insurance plan?

Shall we follow the English pattern and restrict health insurance benefit to the services of the general practitioner of medicine? Or shall we go further; shall we face the facts, and recognize that the burdens of medical costs are due to variations and uncertainties in the cost of medical care, dentistry, hospitalization, and nursing; and accordingly shall we guarantee these four services? Should we go even further and include all kinds of medical care which may be needed and which the community may be prepared to furnish?

5. How shall practitioners and medical agencies be remunerated?

Should the health insurance plan specify that the practitioners shall serve on salaries, or that they shall be remunerated through capitation fees or on a fee schedule? Or should it leave to the practitioners in each community the privilege of electing a system of remuneration? Should hospitals or other institutions be owned by the insurance authority, or should they furnish care through a contract of service in which the actuarial risk is carried by the insurance authority? How shall medical specialists, nurses, dentists, pharmacies, clinics and laboratories be remunerated? Practical procedures must be devised for each of these which is included in the scope of insurance benefit.

6. What would be the total costs of health insurance?

The answer to this question will obviously depend upon the answers to the preceding questions. According as it may be decided what the benefits shall be, what portion of the population shall be covered, and how the system shall be administered, the costs will vary in one direction or another. In any case, there is now available a sufficient mass of information so that the total costs can be anticipated with reasonable accuracy.

7. What shall be the administrative unit?

Should the plan be conceived as national in scope, or should it be developed primarily on a state-wide or even on a smaller basis? Voluntary insurance can be conducted for any unit which is sufficiently large to give actuarial stability to the scheme. Compulsory insurance involves relations to governmental agencies. In the United States, most governmental medical agencies operate on a State-wide basis. Accordingly, there are important arguments which urge a State-wide scope for an insurance plan. There are also important arguments which urge a Federal integration of State plans. The several alternatives must be given close study, especially in the light of developments on the relation of the Federal Government to State systems of unemployment insurance.

8. What shall be the source of the funds and how shall they be raised?

One-fifth of all medical costs are already borne by governmental agencies out of tax funds. It may be assumed that at least this much will continue to come from official sources. How much more should come from taxes? The proportion might range from the present 20 percent up to 100 percent, and might be allocated among various economic classes according to the system of taxation which is employed. Or 80 percent or less of the total might be derived in various proportions by direct or indirect contributions from the consumer public, from those who are specifically embraced by the insurance plan, from wage-earners, from employers, etc. These are questions which in large measure depend upon issues in principle and upon the answers to previous questions.

9. What shall be the administration arrangements for the proposed plan?

The objectives of insurance against medical costs are the same in Maine as in California, in New York City as in an agricultural county in Texas; but the administrative procedures through which these objectives may be attained in one place may be radically different from those which will serve in another. Accordingly, a model bill must provide wide latitude for necessary variations in administrative procedure. Nevertheless, certain basic proposals might be established in principle so that they are applicable everywhere.

Assuming State-wide systems, shall administration follow the pattern which has evolved in the field of workmen's compensation? Shall there be State commissions with executive officers? Or should health insurance be administered through State departments like existing departments of public health? Shall legislation empower a State authority to codify regulations? Shall medical benefits be divided between a minimum which is made mandatory for all insured persons and additional services which are permissive for local groups which desire them, can pay for them and which have the facilities to furnish them? Should service benefits be supplied by local branches of the State authority or through local agencies? How shall financial relations be administered? How shall professional problems be left to the profession and the public interest be adequately safeguarded under professional control? What shall be the procedures for the settlement of judicial questions?

V

These and other questions require careful study; but neither their number or variety should discourage us. The experience of many countries proves clearly that there are no insuperable obstacles to the establishment of a sound system of health insurance. Certainly, it is not in the spirit of our time to be timorous or fearful of attacking the problem. The example which is being set by the President and by administrative and legislative groups everywhere should give us heart and a renewed determination. Indeed, those who have been called to the obligations of high places have a right to expect that all who are competent in the task will devote themselves to the careful and dispassionate formulation of a health plan for the people of the United States.

Senator Donnell. Do you recall any further article which you caused to be published or prepared for publication between the one of June 1934 to which your attention has been directed and that which appeared in the issue of June 1936 of the American Association for Labor Legislation and Review which was entitled, "Cash and Medical Benefits in Health Insurance"?

Mr. Falk. I can't be specific, but I would venture the opinion between that first article to which you refer and which you date as 1934 and another in 1936 that I probably did publish other articles.

I would rather think that an article published in one of the hospital magazines comes between there, though I can't be sure of the dates. It might have preceded the 1934 article. There may have been others.

Senator Donnell. Do you recall the name of that magazine?

Mr. Falk. I think I had an article in the Western Hospital Review in that period, 1934, 1935, and 1936. There may have been others. I think there may have been an article in the Milbank Memorial Fund Quarterly.

Senator Donnell. Do you remember about the date of that?

Mr. Falk. No, sir. I am merely thinking that in the period 1934 to 1936 I wrote and had published a number of articles, and I would be surprised if there were none between the articles you refer to as 1934 and 1936.

Senator Donnell. I offer at this time, Mr. Chairman, the article of June 1936 appearing in the American Association for Labor Legislation Review, entitled, "Cash and Medical Benefits in Health Insurance," by Mr. Falk, who is designated as the head of it. It is formerly Milbank Memorial Fund. I ask that it be incorporated at this point.

Senator Smith. No objection. It is admitted.

(The article referred to is as follows:)

[From the American Association for Labor Legislation Review, June 1936]

CASH AND MEDICAL BENEFITS IN HEALTH INSURANCE

(By I. S. Falk,[1] formerly Research Associate, Milbank Memorial Fund)

There is substantial agreement, if not unanimity of opinion, on the general form which health insurance should take in the United States. Differences of opinion among students of this subject are, in the main, concerned with a few points. Of these, one of the most important is the relation which should obtain between cash and service benefits, and attention may be properly focused here upon this problem.

The two important risks to economic security which arise out of sickness are (*a*) loss of earnings on account of disability among wage earners, and (*b*) the costs of medical care. Formerly, the first of these was the greater; now, the relation is reversed. Each is of sufficient frequency and brings losses of such size and severity as to warrant strong and effective measures of protection. Which is the greater and which is the lesser is, in a sense, of minor importance. Yet a change which has occurred in the relative size of these risks explains the present-day emphasis upon the cost of remedial care.

Among the families with incomes of less than $2,500 a year in the United States, sickness brings the following direct costs:

Family income	Loss of earnings	Costs of medical care
Under $1,200	$250,000,000	$300,000,000
$1,200–$2,500	650,000,000	1,200,000.000

Among the poorest families, medical costs exceed wage loss by only a little; among families in the next higher bracket medical costs are approximately twice as great as the loss of earnings. In still higher income brackets, the ratio between these two sickness costs becomes even greater, because medical costs continue to rise proportionately with income while earnings tend less and less to be cut off during periods of brief or temporary disability.

When the modern movement for health insurance started some 50 years ago, the medical expenditures of the poor were vastly less. Wage loss was, by a large margin, the principal cost of sickness. It was therefore fitting that when national sickness insurance was inaugurated in Germany, the primary insurance benefit was cash in partial replacement of wages lost through disability. Medical care was a more limited and less important benefit. Now, medical benefits account for about 70 percent and cash benefit for only 30 percent of the German insurance budget.

Social insurance against the risks of sickness must recognize the importance of medical costs and of medical benefits. It is not sound to follow European history blindly and design a scheme in which administrative arrangements suitable for the provision of cash benefits are uncritically applied to medical service benefits. It is, if anything, more appropriate to design administrative procedures with first attention to the service rather than to cash benefits, because it is a much more complex task to furnish service benefits than to dispense cash. Every system which has failed to recognize this has experienced profound and disruptive disagreements between the insurance authorities and the professions.

Cash (wage loss) benefit for the disabled wage earner requires a certification as to the existence of the disability. It has been traditional for this certification to be made by the patient's own doctor—his treating physician. It is therefore not surprising that many an insured person chooses his insurance physician with one eye on his reputation for professional competence and the other on his reputation for liberality in the issuance of certificates of disability. The consequences of this practice are far reaching not only for the quality of medical care but also for the finances of the scheme.

To what extent the conjunction of treating insured persons and of certifying as to the disability of sick persons who are gainfully occupied has adversely affected the quality of the service benefits cannot be measured quantitatively. It is beyond peradventure that this effect has been grossly exaggerated by some American opponents of health insurance. All authoritative evidence testifies that the influence of insurance to improve medical practice has been more than sufficient to offset this degrading force. There can be no doubt, however, from the views expressed either openly or confidentially by the authorities in insurance countries that there is ground in experience to justify the strongest objection against placing the traditional dual responsibility upon insurance physicians.

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[1] Dr. Falk is author of the new book, Security Against Sickness—A Study of Health Insurance, America's Next Problem in Social Security (Doubleday, Doran & Co., 1936).

The financial effects of overcertification can be indicated only in approximate terms. For example, even in Great Britain where the relations between the medical and the insurance authorities are probably more wholesome and cooperative than in any other large insurance country, overcertification is quite extensive despite concerted efforts to control it. In 1934, with 15,500,000 insured persons, there were 468,600 references to the regional medical staff for advice as to incapacity for work. Of these, 134,700 received a final certificate before the date fixed for examination and 86,600 failed to attend for other reasons. Of the 246,100 who were examined, incapacity for work was confirmed in only 179,000 cases.

The annual cost of cash benefits furnished to insured persons who are improperly or dishonestly certified as disabled is not known; but these figures indicate that the cost must be considerable. The regional medical staff costs only a small percent of the total cost of administration. Spurious cash benefits undoubtedly cost a great deal more. From such evidence as is available for Germany, where the cash benefits are more attractive than in Great Britain, it is clear that the situation there has long been—if anything—much worse.

The result of assigning a dual function to the insurance physician is more far reaching than the direct effects on the quality of medical practice or than the costs could show. In a hundred ways, differing greatly in various countries because of the different administrative arrangements, the duality of function leads to irritation and friction between the physicians and the insurance authorities and tends to keep these two important groups from that sympathetic relation to which their common interest in the insured persons should otherwise lead them.

If there is to be separation of administrative function between cash and service benefits, how far should this go? There are apparently two broad alternatives among those which have been proposed. One is to keep the two benefits within the same insurance scheme, but to divide the medical responsibility by requiring that certification shall be a function of salaried, whole-time medical officers who may not engage in private practice. In this proposal, the treating physicians would be limited to recommend certification but would be without final authority to certify. Like the supervising physicians of the German Krankenkassen the Vertauensaerzte) the salaried medical officers should be assured permanent tenure and a retirement annuity to protect them against pressure to issue certificates which might otherwise be exerted by patients or by practicing physicians. The other alternative is more drastic; it proposes that health insurance be restricted to the service benefits and that the cash benefits be relegated to the system of unemployment compensation. On this basis, the cash disability benefit would be treated as a compensation payable during a period of unemployment when the unemployment is caused by inability to work. In this case, certification would, as also in the other plan, be a responsibility of independent, salaried, medical officers and the cash (disability) benefit would be payable by the same office to which the socially insured person looks for other cash benefits.

The cost of a salaried medical staff to certify disability can be only roughly estimated. Though it would amount to an appreciable part of the total cost of administration, it may be expected to lead to a much larger saving through the conservation of cash-benefit funds. On this ground alone—though it is not the only or perhaps even the most important ground—the salaried medical staff would be worth more than it would cost.

If it is assumed—as is proper to do, and in accord with the principles laid down by the staff of the President's Committee on Economic Security[2]—that health insurance in the United States should be conceived primarily on a State-wide basis with Federal subsidies, grants-in-aid, or other incentives, Federal minimum standards might properly leave to the several States a final decision on the extent to which the one or the other alternative outlined above is followed in separating cash from service benefits.

The medical-political leadership which has recently opposed health insurance in the United States has not been opposed to disability (cash benefit) insurance.

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[2] Report to the President by the Committee on Economic Security. Government Printing Office, Washington, D. C., January 15, 1935.

> Of its objections to medical-care insurance, the only type of argument it has mustered which has had a substantial basis in experience or fact rests on the confusions and the deficiencies created by the dual functions assigned in European schemes to insurance physicians. Administrative separation of the cash and service benefits would meet the objections which have been raised by sincere critics and would cut the ground from under the others.
>
> In European health insurance countries one is frequently told that if their schemes were to be planned over again, cash and service benefits would be separated as widely as would be practicable. In America, voluntary health insurance has generally and from its beginning placed more emphasis on service than on cash benefits, being different in this respect from the voluntary insurance which preceded compulsory health insurance in Europe.
>
> Finally, it is interesting to note that the British Columbia health insurance law passed by the provincial legislature only a few weeks ago (March 31, 1936) is entirely restricted to service benefits. This is perhaps a straw in the wind.

Senator DONNELL. Mr. Falk, in a footnote to this last article I referred to appears this language [reading]:

> Dr. Falk is author of the new book, Security Against Sickness—A Study of Health Insurance, America's Next Problem in Social Security (Doubleday, Doran & Co., 1936).

That book was published by you, was it not, caused to be published by you?

Mr. FALK. Yes, sir.

Senator DONNELL. Was it widely circulated, do you recall?

Mr. FALK. Well, I don't know what the word "widely" means in this connection.

Senator DONNELL. Do you know approximately how many volumes?

Mr. FALK. I think there were something like two or three thousand copies printed and a considerable portion of those were sold, circulated, distributed.

Senator DONNELL. What was the next publication after the book to which I have referred by yourself on the general subject of health insurance?

Mr. FALK. I am sorry, Senator, I couldn't tell you just what was the next publication. You are referring here to a chronology that goes back 12 years, and I wouldn't remember that. If I had guessed that you were interested in the chronology of my publications, I would have been very glad to have it and furnish you with a complete list.

Senator DONNELL. Mr. Falk, would you mind doing that very thing, furnishing to us a chronological, complete bibliography of your publications on the general subject of health insurance or related subjects?

Mr. FALK. And related subjects?

Senator DONNELL. Yes.

Mr. FALK. Yes, sir; I will be glad to.

Senator DONNELL. You will furnish that to this committee please, Mr. Falk.

Mr. FALK. Yes, sir.

(The material referred to appears on pp. 1910–1914.)

Senator DONNELL. We will proceed then from the matters of these publications. Have you also engaged in public speaking on the subject of health insurance, Mr. Falk?

Mr. FALK. Some, but very little.

Senator DONNELL. Do you remember the first public address you made on that subject and where it was, what organization?

Mr. FALK. Well, I wouldn't venture anything in the nature of a confident guess as to what was the first occasion. I can think back having spoken on that subject somewheres about 1934. It might have been 1933, it might have been '34, before the New York Academy of Medicine—before an audience at a special meeting of the New York Academy of Medicine. I wouldn't be sure that was the first, though.

Senator DONNELL. Do you recall the subject of that address?

Mr. FALK. Well, it had something to do with this general field, but I don't profess to remember.

Senator DONNELL. Were you advocating a compulsory health insurance in that address?

Mr. FALK. I don't remember that. Much more likely it was a discussion of the problems that are involved in improving health services in the United States and making it more generally and more easily possible for people to receive adequate care, and elements that go into that.

I doubt very much that it had to do with any specific or particular program, though it may have included the advocacy of health insurance as one of the measures.

Senator DONNELL. Did you deliver an address before the annual fall conference of the New York Women's Trade Union League in New York on October 1, 1938, on the subject of the national health program?

Mr. FALK. I think I did, though I am not positive of that, Senator.

Senator DONNELL. Will you take a look at this and see if that is the address?

Mr. FALK. Yes; I think that is correct.

Senator DONNELL. The opening sentence I will read from that address. [Reading:]

> I am glad to have this opportunity to address the annual fall conference of the New York Women's Trade Union League, and to review the health program recently submitted to the public by the President's Interdepartmental Committee.

This was in October of 1938. At that time do you know whether Mr. Michael Davis was connected with the division of health studies in the social security organization here in Washington?

Mr. FALK. Well, I will tell you in a moment accurately, Senator, rather than just make a guess at it. You see, Mr. Michael Davis was one of a number of persons who had been appointed as consultants to the Bureau of Research and Statistics. According to my record, he was appointed in March 1938.

Senator DONNELL. Did you present a paper at the special session on content and administration of a medical care program before the American Public Health Association in New York City on October 4, 1944?

Mr. FALK. Yes, sir.

Senator DONNELL. Were you on a certain subcommittee on medical care of the committee on administrative practice of the American Public Health Association in June of 1944?

Mr. FALK. Yes, sir.

Senator DONNELL. And did that subcommittee consist of yourself and Messrs. Daily, Reed, Rogers, and Sinai?

Mr. FALK. Not a subcommittee of the committee on administrative practice. You are referring to some other subgroup, aren't you, Senator?

Senator DONNELL. I call your attention to this, particularly this part that is marked.

Mr. Falk. Would you repeat the question, Senator.

Senator Donnell. Read the question.

(The reporter read back the last question.)

Mr. Falk. No, sir. Let me explain that.

Senator Donnell. Certainly.

Mr. Falk. The committee on administrative practice, one of the standing committees of the American Public Health Association, had appointed a subcommittee called a subcommittee on medical care.

That subcommittee of the association's standing committee, at one stage in its work, appointed from among its membership a smaller group to do a particular job. I don't believe that ever had the status of any particular committee. That subgroup, if I may call it that, included four of the names I think you mentioned. As for the membership of the committee, the fifth person you mentioned [Mr. Reed] was not a member of the committee. He was merely a technical assistant, there by the direction and the courtesy of the chairman of the subcommittee.

Senator Donnell. I read into the record at this time from the minutes of the third meeting of the subcommittee on medical care of the committee on administrative practice these two paragraphs appearing on page 3 [reading]:

> The chairman then raised the question of the need for a progress report to the committee on administrative practice and if the reaction of the latter were favorable to the whole association. Such a report would give the gist of the committees thus far and would present a framework within which subsequent reports could follow.
>
> It was agreed that such a report was desirable. The committee accordingly turned to consideration of the draft report on a national health plan which Dr. Sinai presented on behalf of the subcommittee (Daily, Falk, Rogers, and Sinai) which had been given responsibility at the last meeting of the committee for drafting a program.

Is that a correct copy, Mr. Falk, of the minutes as you see them?

Mr. Falk. Yes, sir; but as my remark may have indicated, it is not an altogether precise statement of the facts.

Senator Donnell. The chairman of the subcommittee on medical care was Dr. Joseph W. Mountin, that is correct, is it not?

Mr. Falk. Yes, sir.

Senator Donnell. We have considerable evidence in the record, as you know, in regard to this particular report and subsequent developments on it. I don't know whether you read that portion of the evidence or not.

Mr. Falk. Yes, sir; there is a good deal there, some of which is accurate and some of which leads to misunderstanding.

Senator Donnell. Now Mr. Falk, the report of the Health Program Conference published with the cooperation of the Committee on Research in Medical Economics in 1944 met with your approval, did it not?

Mr. Falk. Yes, sir.

Senator Donnell. And included in that report, pages 12 and 13 is this language, is it not? [Reading:]

> Finances: The chief support of a Nation-wide system of medical care should be contributory insurance required by law with the amounts of payment from employees, employers, and self-employed persons relating to the earnings of the contributors combined with the support from general taxation.

Do you agree to that statement?

Mr. FALK. Yes, sir; but unless I misheard you, did you say relating or related?

Senator DONNELL. Related, I should have said.

Mr. FALK. For the record I thought you wanted it accurate.

Senator DONNELL. We certainly do. [Reading:]

persons related to the earnings of the contributors.

Is that what you said?

Mr. FALK. Yes, sir.

Senator DONNELL. All right. Referring again to your addresses, do you have a list of all those addresses which you have made, Mr. Falk, which you could furnish us too? I don't mean the addresses themselves but a bibliography of the addresses as well as the publications.

Mr. FALK. I will be glad to furnish you a list containing all of which we have any records.

Senator DONNELL. Very well, you will do that, Mr. Falk.

(Subsequently Mr. Falk addressed the clerk as follows:)

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
BUREAU OF RESEARCH AND STATISTICS,
Washington, D. C., March 16, 1948.

Mr. PHILIP R. RODGERS,
Clerk, Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

Dear Mr. RODGERS: When I was testifying before the Subcommittee on Health on January 27, 1948, Senator Donnell requested a chronological list of all my publications (p. 226) and addresses (p. 232) on the general subject of health insurance and related subjects.

The enclosed list includes—to the best of my knowledge—all my publications and addresses on health insurance and related subjects. I have combined addresses and publications rather than making two lists. A reference might be inserted on page 232 of the transcript indicating the list of addresses is included in the list of publications which appears on page 226 of the transcript.

Sincerely yours,

I. S. FALK, *Director.*

MARCH 12, 1948.

I submit the following list of my addresses and publications, requested by the Subcommittee for inclusion here, on health insurance and related subjects. This list has been prepared from available files. To the best of my knowledge, it is complete with respect to the indicated subjects.—I. S. Falk.

1918 "The Case for Health Insurance." General Federation Magazine, December, 1918, pp. 21–23.

1932 "A Community Medical Service Organized under Industrial Auspices in Roanoke Rapids, North Carolina" by I. S. Falk, Ph. D., Don M. Griswold, M. D., Dr. P. H., and Hazel I. Spicer. With Reports on Certain Phases of the Organization by David Riesman, M. D., Sc. D., and George P. Muller, M. D. (Publication No. 20, The Committee on the Costs of Medical Care.) Chicago. The University of Chicago Press, Sept. 1932, 109 pp.

"Organized Medical Service at Fort Benning, Georgia" by I. S. Falk, Ph. D. With Reports on Certain Phases of the Organization by David Riesman, M. D., Sc. D., and George P. Muller, M. D. (Publication No. 21, The Committee on the Costs of Medical Care.) Chicago. The University of Chicago Press, Nov. 1932, 119 pp.

"Surveys of the Medical Facilities in Three Representative Southern Counties" by C. St. C. Guild, M. D., Dr. P. H. With a Statistical Appendix on the Method of Selecting Representative Counties by I. S. Falk, Ph. D. (Publication No. 23, The Committee on the Costs of Medical Care.) Chicago. The University of Chicago Press, Dec. 1932, 173 pp.

1933 "The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families: Experiences in Twelve Consecutive Months During 1928–31" by I. S. Falk, Ph. D., Margaret C. Klem, Nathan Sinai, D. P. H. (Publication No. 26, The Committee on the Costs of Medical Care.) Chicago. University of Chicago Press, Jan. 1933, 327 pp.

"The Costs of Medical Care: A Summary of Investigations on the Economic Aspects of the Prevention and Care of Illness" by I. S. Falk, Ph. D., C. Rufus Rorem, Ph. D., C. P. A., and Martha D. Ring. (Publication No. 27, The Committee on the Costs of Medical Care.) Chicago. University of Chicago Press, Jan. 1933, 623 pp.

"Fundemental Facts on the Costs of Medical Care." The Quarterly Bulletin, Milbank Memorial Fund, Vol. XI, No. 2 (April 1933), pp. 130–153.

1934 "The Present and Future Organization of Medicine." The Quarterly Bulletin, Milbank Memorial Fund, Vol. XII, No. 2 (April 1934), pp. 115–125.

"Changes in Paying for Hospital Care Considered from a General Economic Point of View." Western Hospital Review, Vol. XXII, No. 4 (June 1934), pp. 7, 18–20.

"Formulating an American Plan of Health Insurance." The American Labor Legislation Review, Vol. XXIV, No. 2 (June 1934), pp. 87–94.

"Current Problems in Medical Economics," an address before the Committee on Medical Economics, Stamford Medical Society, Stamford, Connecticut, February 27, 1934.

"Opportunities for Voluntary Insurance," an address before the Suburban Club, Stamford, Conn., March 26, 1934.

"Outline of a Plan for Insurance Against the Costs of Medical Care," a report presented at the 12th Annual Conference of the Advisory Council of the Milbank Memorial Fund on March 14–15, 1934, at the New York Academy of Medicine. Printed in the Proceedings.

"Costs of Medical Care," an address before the Y. W. C. A. Forum, Philadelphia, Pennsylvania, May 7, 1934.

1935 "Compulsory Health Insurance." Social Work Year Book (3d issue), New York. Russell Sage Foundation, 1934, pp. 86–89.

"Present Trends in Health Insurance." Radio Address, the Columbia Broadcasting System in the "Doctors, Dollars, and Disease" series (Public Health Series, Lecture No. 17), February 11, 1935. The University of Chicago Press, 6 pp.

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Mr. FALK. Yes, sir. Excuse me, would you define the area or the period of time?

Senator DONNELL. On the subject of health insurance or related subjects in the judgment related to health insurance and the period at any time beginning in 1918 on down to the present time.

Mr. FALK. Yes, sir; I will be glad to.

Senator DONNELL. Mr. Falk, have you in the course of your work had occasion to examine into the New Zealand situation, relative to operation of health insurance?

Mr. FALK. I have done a little reading on the subject myself, and I have had members of my staff look into it more thoroughly.

Senator DONNELL. Is Mr. Wilbur J. Cohen connected with your staff?

Mr. Falk. Yes, sir; he is.

Senator Donnell. In what capacity?

Mr. Falk. He is assistant director of the Bureau.

Senator Donnell. Is he here this morning?

Mr. Falk. He was here earlier. Yes, sir; he is here.

Senator Donnell. Would you state whether or not, in the course of your study, you came into contact with a Dr. W. B. Sutch?

Mr. Falk. No, sir; I did not.

Senator Donnell. Do you know whether Mr. Cohen had contact with Mr. Sutch?

Mr. Falk. Yes, sir; I understand he did.

Senator Donnell. Did you receive from Mr. Cohen a report dated February 15, 1946, with respect to an appointment which he had with Mr. Sutch?

Mr. Falk. Yes, sir. I have no personal recollection of that, but I believe our office files indicate that I did. At any rate, when that document came to our attention through the investigations of Mr. Harness's subcommittee in the House of Representatives and the release of this document to which you refer, the reference to it in one of Mrs. Shearon's letters and the publication of that document in at least one private publication, it came to my attention again.

Senator Donnell. What was that private publication to which you refer?

Mr. Falk. A magazine entitled "Medical Economics" has printed what purports to be and what I believe is a reproduction of a photostat copy of that document which had been drawn from our official files by a committee of the House of Representatives.

Senator Donnell. The article in Medical Economics to which you refer is that which appears in the December 1947 issue beginning at page 46 entitled, "The Man Behind the Wagner Bill"?

Mr. Falk. Yes, sir.

Senator Donnell. And is that the article which contains a photograph of yourself and quite an extensive statement with respect to your connection with the various Wagner-proposed legislation, is that right?

Mr. Falk. Well, that is partly correct. It contains what looks to me like some kind of a touched up photograph of me. [Laughter.]

Senator Donnell. Do you know who the author of that article is?

Mr. Falk. Do I know, you say?

Senator Donnell. Yes.

Mr. Falk. No, sir; I can't say that I know who it was.

Senator Donnell. Do you know what this publication is, where it is published and who the editor is?

Mr. Falk. It was published, I believe, in Rutherford, N. J., if I remember the address correctly. The editor is a Mr. Richardson, whom as far as I know I have never met, but whose name I have known and with whom I have had some exchange of correspondence on various occasions on other matters and also with respect to this article.

Senator Donnell. That is Mr. William Alan Richardson, is it, Mr. Falk?

Mr. Falk. That sounds right.

Senator Donnell. The editor in chief is Mr. H. Sheridan Baketel?

Mr. Falk. I think that is correct.

Senator DONNELL. The photograph to which you refer appears on page 47, and I observe on the page which gives the contents that that is a Harris & Ewing photograph. Are you familiar with that firm in Washington?

Mr. FALK. Yes, sir; I am, and I have meant to get a copy of that photograph and see how near this is a copy of the Harris & Ewing photograph, or whether it is something else.

Senator DONNELL. At any rate, the opening portion of this publication describes it as coming from this organization. It also contains a photograph of Mr. Cohen, does it not?

Mr. FALK. Yes, sir; it does. I am not sure whether that is a true photograph or whether it is touched up.

Senator DONNELL. Do you think it is touched up also?

Mr. FALK. It gives him a very stern look, which I am not accustomed to see on him.

Senator DONNELL. It also gives a photograph of Mr. Barkev S. Sanders, chief of the research bureau operated by yourself.

Mr. FALK. Yes, sir. That looks like a natural picture of the man.

Senator DONNELL. It gives a picture on page 49 of Ida C. Merriam, does it not?

Mr. FALK. Yes, sir.

Senator DONNELL. By the way, is Mr. Sanders here this morning?

Mr. FALK. No; as far as I know.

Senator DONNELL. And Miss Merriam?

Mr. FALK. No; as far as I know.

Senator DONNELL. Miss Margaret C. Klem, her picture is here also, is it not?

Mr. FALK. Well, I can vaguely with some confidence agree that might be she, but it is not a very good picture of her.

Senator DONNELL. Very well, and also a picture of Mr. Altmeyer and a copy of a photostatic copy marked "File copy" of this report of February 15, 1946, is that right?

Mr. FALK. Yes, sir.

Senator DONNELL. Very well. Now in this report from Mr. Cohen dated February 15, 1946 appears this language [reading]:

> I had an appointment yesterday with Dr. W. B. Sutch, formerly of the New Zealand Ministry of Finance who is now working with UNRRA. I took Mr. Fisher with me to talk with him.

Might I ask a question there, Mr. Falk. Do you know which Mr. Fisher that is?

Mr. FALK. Mr. Jacob Fisher.

Senator DONNELL. Proceeding with the letter, is Mr. Jacob Fisher connected with your department?

Mr. FALK. With my bureau; yes, sir, he is a member of our staff.

Senator DONNELL. Proceeding now with the letter [reading]:

> Dr. Sutch was intimately connected with the formulation of the medical care plan in New Zealand. He knows the New Zealand Minister of Health very well, and also knows Dr. Robb. During the conversation I asked him whether he had any statement on the New Zealand medical plan which might be used to prove that the statements made by the American Medical Association concerning the failure of the New Zealand system were false.

Might I inquire whether or not, Mr. Falk, Mr. Cohen in making this inquiry of Dr. Sutch was acting pursuant to direction from yourself?

Mr. FALK. May I say first that I have no recollection of this memorandum until it came to my attention recently when Mr. Harness' committee had drawn it from the file, and after I saw reference to it in one of Mrs. Shearon's letters, or what purported to be one of her letters.

I do know this; that at the time to which this memorandum refers, Mr. Cohen was working in this field, acting in this field under a general instruction which applied to various members of our staff, because the Chairman of the Committee on Education and Labor had on several occasions asked me for information that we might have available concerning the operation of the social security system in New Zealand.

Senator SMITH. You mean Senator Murray?

Mr. FALK. Yes, sir. I am sorry. I meant to mention his name. I am sorry I didn't.

Various members of our bureau knew of that request. I think several of them at least also knew that I had even gone so far as to communicate with the New Zealand authorities for information on this subject. We didn't have very much, beyond a certain point, as to what had been happening and what was going on and what experience in New Zealand was.

Consequently, as I understand it—I am not speaking from first-hand knowledge but from Mr. Cohen's reports to me—when he learned that a New Zealander named Dr. W. B. Sutch was here in Washington and that he had or may have had some first-hand knowledge about the New Zealand social security law, as I understand it Mr. Cohen arranged to meet Mr. Sutch, Dr. Sutch.

Senator DONNELL. Pardon me. The expression "Dr. Sutch," do you know if he is a medical doctor or is that a PhD?

Mr. FALK. I think he is a PhD. I used the phrase "doctor" because that is how he is addressed in the memorandum to which you referred, Senator.

Senator DONNELL. You do not know whether he is a medical doctor?

Mr. FALK. I think he is not. I will tell you in a moment, because one of the documents which I have here gives something about this training. I believe he is an economist, Senator, who has held various positions as economist in the Ministry of Finance in New Zealand, the ministry which is responsible for introducing their social security legislation, and the Ministry of Supply of New Zealand, and apparently played some part in the development of their social security program.

Senator DONNELL. Proceed, Mr. Falk.

Mr. FALK. Now I was saying, as I understood it—I am telling you what Mr. Cohen reported to me. Mr. Cohen found it possible to arrange an appointment with—may I call him Mr. Sutch?

Senator DONNELL. He is a Ph. D., I understand.

Mr. FALK. And he made an appointment to see him at his UNRRA office. He took Mr. Fisher with him. Of course, Mr. Fisher, a member of our staff, had a much more extensive knowledge of the New Zealand social security system, perhaps, than any other person in our staff, and had made a study of the new Zealand plan. I believe he may already by this time have published either one or two documents on the New Zealand program.

Mr. Cohen has reported that his purpose in going to see Mr. Sutch was to have a general discussion with him, to get factual information and his viewpoint on various matters on which the New Zealand program was at that time being criticized. That was the reason why Senator Murray had asked us for what information we might have on the subject.

In discussing the subject with Mr. Sutch, Mr. Cohen said he referred to articles published in the United States. He reported that Mr. Sutch was very indignant about them, stating that many of the criticisms of some of those criticisms that had been published in this country were half truths or were erroneous, and were based on misunderstandings of the New Zealand situation.

Mr. Sutch told Mr. Cohen, as I understand it, that if he were staying in the United States longer he would have liked to have written a statement giving what he regarded as a true picture of the New Zealand program, and which he thought would refute many of the criticisms that were being circulated.

Mr. Cohen further reported that he mentioned to Mr. Sutch that the chairman of the Senate committee, Senator Murray, had asked us for information on the New Zealand plan and on these criticisms that were floating around, and that if Mr. Sutch had time to prepare such a statement, he was sure it would be very welcome to Senator Murray.

As I understand it, Mr. Sutch told Mr. Cohen that he didn't have time to prepare such a statement, since he was leaving the United States very shortly, but that he would be very glad to discuss his views at length with Mr. Cohen and Mr. Fisher, at length and in detail, and asked them then that if it would be useful at the conclusion of their discussion, if they would write up what he said he would be very glad to review it and revise it, sign the statement and send it or have it sent to Senator Murray.

Mr. Cohen further reported that Mr. Fisher and he then discussed the New Zealand situation at some length, with Mr. Sutch going into detail with respect to the technical aspects of the New Zealand plan; that Mr. Sutch gave him a detailed explanation about various provisions of the New Zealand plan, law, financing, and administration; and that after an extended conversation on many of these points he or they—Mr. Cohen and Mr. Fisher— agreed to comply with Mr. Sutch's request and prepare a rough draft of the statement which Mr. Sutch had just given them, embodying the views that he expressed to them in that discussion.

Mr. Cohen said he asked Mr. Fisher, who was familiar with the technical details of the New Zealand plan, to prepare a rough draft based on Mr. Sutch's statements, his comments and opinions. Mr. Fisher prepared such a statement and that statement was sent to Mr. Sutch in rough draft.

Mr. Sutch read and reviewed that statement. He edited it, made various deletions, additions and changes, and agreed that the amended statement represented his views, and he expressed that opinion without any qualification whatsoever, and that he wished to have it transmitted to Senator Murray.

May I be allowed to say at that point, Mr. Chairman, that had the investigator of Mr. Harness's committee who drew from our files that memorandum of Mr. Cohen's addressed to me, which Senator Donnell has—had that investigator taken from our files not merely that document but such additional documents as would correctly portray what happened, that investigator would also have taken from the file, because it was in the same file, not only a copy of the document that went to Mr. Sutch but the copy which he returned with his changes and editing and amendments and revisions; so that it never could have been said, as it has been said, that the document prepared in rough draft by Mr. Fisher, at Mr. Cohen's direction, to record Mr. Sutch's expressions and opinions as he had asked them to do, it never could have been said that the document prepared by Mr. Fisher under those circumstances was used as such without the dotting of an "i" or the crossing of a "t"; because the fact is that Mr. Sutch made various and substantial changes in that document in order to conform it to his views and opinions.

I refer to this because I think it is very unfortunate that a misunderstanding of a matter of this kind should arise because someone drew from our official files a single piece of paper or a few select pieces of paper and encouraged or permitted or otherwise participated in the utilization of those documents to give a story as though it were the true or the whole or the correct story when it was not.

I have here before me not only the photostat of the Cohen memorandum which you have, Senator—perhaps it is a duplicate of that photostat—but also a photostat of a memorandum from Mrs. Merriam addressed to Mr. Cohen, referring to the statement by Mr. Sutch.

I am taking these out of order. I referred to the Cohen memorandum which Senator Donnell has. I have also a photostat of the document which was in the same file from which that was taken. It is the draft that was sent to Mr. Sutch and returned by him with his changes and revisions and so forth, under a covering letter from him addressed to Mr. Cohen in which he says [reading]:

> I am enclosing my revision of the social security statement. You will note that I have not made many changes.

I read that but I would like to remark that the document speaks for itself as to whether he made many changes.

Senator DONNELL. Do you know how many he did make?

Mr. FALK. I haven't counted them, Senator, but there are changes on, I hesitate to say in advance, every page of the memorandum, I believe.

Senator DONNELL. Mr. Falk, do you mind putting into the record these various photostatic copies from which you are reading?

Mr. FALK. I am very glad to do so, Senator, because I think taking them altogether they give a fairer and a more nearly correct picture of an episode which I think has been misrepresented and misunderstood, and which has been made to seem to be something very different from what it was.

Senator DONNELL. Mr. Chairman, it would be very well indeed to have this entire sequence in the record.

Senator SMITH. I think so.

Senator DONNELL. I move, Mr. Chairman, that they be incorporated in the record. With Mr. Falk's consent they will be copied into the record and the copies will be returned to him.

Mr. FALK. Thank you, Senator.

Senator SMITH. Might I ask, Senator Donnell, the purpose is to have the record show the changes that have been made in the document?

Senator DONNELL. I think that should appear.

Senator SMITH. I think that is important. Does your record, Mr. Falk, show those changes so it could be readily put into the record by the reporter?

Mr. Falk. Well, that is a photostat copy, Senator, of the document containing the changes as they were made.

Senator Smith. That's all right, exactly the way the document was made.

Senator Donnell. I am going to suggest, Mr. Chairman, that when it is made up in the final record, that if practicable it be in photostatic form.

Mr. Falk. It would be very interesting then to notice, Senator, if I may just direct attention to this one part, as submitted to Mr. Sutch as the memorandum of February 19, 1946, it was entitled, "Draft Statement for Mr. W. B. Sutch of New Zealand." As it came back to us from him he had made the verbalistic changes and the heading now reads not a draft statement for Mr. Sutch but, "Statement by Mr. W. B. Sutch of New Zealand."

It is changes of that kind which I think the record ought to show.

Senator Donnell. Of course that is perfectly natural if he were making a statement, he wanted to show it was a statement by himself.

Mr. Falk. Quite so, Senator, and that is precisely the point I make; because this material has been used, having been taken from our files by an investigator and given out—apparently, or however, I don't know. It has been utilized in private publications, copyright documents, and made to appear as though we, that is, members of our staff, had prepared a statement and made it available to a Member of the United States Congress purporting to be a statement of Mr. W. B. Sutch, but as though we had done that on our own responsibility, on our own authority, and as though we were putting under his name our views rather than his, and as though that had been done wholly by us without his active participation, cooperation or direction or request. It is because of that, it seems to me, grave misunderstandings have arisen in this whole subject which this committee is exploring—because of just such misrepresentations on this particular episode. And I thought this committee would welcome having this episode straightened out in the record.

Senator Donnell. I think we should have the material in full in the record as you have given it. I should like to continue reading Mr. Cohen's letter to yourself of February 15. He says, after what I have already read [reading]:

> When I showed the AMA statements to Dr. Sutch he was very indignant and said he would be willing to send a statement saying that they were false. He agreed to make such a statement providing that we would make a first draft or what it was we wanted to say which he would go over. I told him that if he made such a statement we could use it by including it in the committee prints of the Senate Education and Labor Committee.
>
> I have asked Mr. Fisher to draft such a rough statement to give to Dr. Sutch. We will have to get it to him by next Tuesday or Wednesday, since he is leaving the country shortly.

Mr. Falk. Shortly?

Senator Donnell. Now might I also state at this point that the first page of the draft statement, photostatic copy of which I have in my hand reads in part as follows [reading]:

> Statement prepared for Mr. Sutch by Jacob Fisher delivered to Mr. Sutch by Mr. Fisher February 19, 1946. Draft statement for Mr. W. B. Sutch of New Zealand.
>
> During my present stay in the United States, I have been struck by the character of some of the—

and right at that point a word has been inserted in handwriting, "unwarranted"—

> unwarranted criticism leveled against the New Zealand health-benefit program, viz:
> 1. That it is socialized medicine.
> 2. That it has resulted in deterioration in the quality of medical care.
> 3. That it has led to unreasonable patient demands on the time of the doctor.
> 4. That it has been abused by the doctor.
> 5. That it faces failure and bankruptcy.

Now may I ask you, Mr. Falk, who was it, was it Dr. Sutch or was it Mr. Fisher or who was it that thought of these five points here to point out as criticisms that had been leveled against the New Zealand health-benefit program?

Mr. FALK. Senator, I have no personal knowledge of that. I can tell you my understanding is that they stated here what had developed in their conversation with Mr. Sutch as his views.

I can't give you any more detailed information on that, but since Mr. Cohen is in the room and he personally partook in this field, if the committee wants to pursue that and wants more authoritative information, I presume he would be very glad to give all the information at his disposal.

Senator DONNELL. I think we might have Mr. Cohen step forward, if he will. Is he here? I want to see whether that photograph does him justice at this point, too.

Mr. COHEN. I think it is a pretty good photograph, Senator.

Senator DONNELL. Will you please state your name for the record?

STATEMENT OF WILBUR J. COHEN, BUREAU OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION

Mr. COHEN. My name is Wilbur J. Cohen. I am assistant director of the Bureau of Research and Statistics, Social Security Administration.

Senator DONNELL. How long have you had that office, Mr. Cohen?

Mr. COHEN. I have been with the Social Security Board since its inception and I was appointed assistant director of the Bureau of Research and Statistics I believe in 1940 or 1941 or thereabouts.

Senator DONNELL. You know Mr. Jacob Fisher, do you?

Mr. COHEN. I do, sir.

Mr. DONNELL. Is that the same Jacob Fisher that is referred to in the Harness report of House Report No. 786, at page 7?

Mr. COHEN. I believe it is, Senator.

Senator DONNELL. I would like to read into the record a few sentences here that relate to Mr. Fisher in that report. [Reading:]

> We find that this same Jacob Fisher has been documented by the House Committee on Un-American Activities for almost uninterrupted association, since 1939, with various Communist-front and fellow-traveler organizations in the United States.
>
> At various times, according to his record, Jacob Fisher has been identified with seven different groups or organizations avowedly sponsoring the Moscow party line in the United States. He has published at least one report on health insurance in New Zealand, in the Social Security Bulletin—a report which has been criticized by some reputable medical authorities as extremely biased.

Who is Mr. Fisher? What is his official connection with any governmental organization?

Mr. COHEN. Well, Mr. Fisher, Mr. Jacob Fisher is a member of the staff of the Bureau of Research and Statistics.

Senator DONNELL. Of the Social Security Administration?

Mr. COHEN. Yes, sir.

Senator DONNELL. How long has he been occupying that office, if you know?

Mr. COHEN. I don't remember exactly. I think our records will show probably 6, 7, 8 years or longer. He was formerly, Senator, employed in another bureau of the Social Security Administration, the Bureau of Public Assistance, prior to his employment in the Bureau of Research and Statistics.

Senator DONNELL. Is that the same Jacob Fisher whose name appears as the author of the pamphlet entitled "Cash Benefits Under the New Zealand Social Security Program," issued by Federal Security Agency, Social Security Board, Bureau of Research and Statistics, Bureau Report No. 13?

Mr. COHEN. Yes, sir.

Senator DONNELL. Now your official connection, you say, is assistant director, that is to say, Mr. Falk is the Director of the Bureau of Research and Statistics and you are next to him in line as assistant director, is that right?

Mr. COHEN. That is correct, sir.

Senator DONNELL. Your name appears on this same booklet under the heading of Bureau of Research and Statistics opposite Mr. Falk?

Mr. COHEN. That is correct.

Senator PEPPER. You were reading from the Harness report?

Senator DONNELL. Yes, I was.

Senator PEPPER. Does the report name the alleged Communist-front organization?

Senator DONNELL. I don't know whether it does at any other point. It doesn't at this point. I do not know. It says this, however—I read this in view of the Senator's request—It says, following what I have read [reading]:

> In a later interim report on the propaganda activities within the Social Security Board, we shall present to the Congress the detailed record of Jacob Fisher's activities, as certified to us by the Committee on Un-American Activities, together with additional material bearing upon organized communist agitation for what certain witnesses and authors of propaganda refer to as socialized medicine, through such agencies as the Southern Conference for Human Welfare.
>
> Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow-travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard.

This is approved by Forest A. Harness, James W. Wadsworth, Henry J. Latham, Carter Manasco, and J. Frank Wilson.

Senator PEPPER. Does the Senator recall whether the Department of Justice or the Attorney General have designated the Southern Conference for Human Welfare as a Communist-front organization?

Senator DONNELL. I have no recollection on that.

Senator PEPPER. The record doesn't show whether any of the organizations mentioned by the Harness Report as Communist-front organizations have been so labeled by the Department of Justice or the Attorney General?

Senator DONNELL. Our record does not. I do not know what the records disclose.

Mr. FALK. Mr. Chairman, may I interject a remark concerning those charges from the Harness committee. At the time Mr. Harness launched that attack upon us, including these criticisms of Mr. Fisher, he did it on the floor of the House, with no prior consultation with the Federal Security Agency or the Social Security Administration or the Bureau. There was no consultation, no hearings, as far as we know no opportunity given anyone to hear the charges or to consider them or for the individual or individuals concerned to make any defense.

Immediately after those charges were made, the officers of the Federal Security Agency and its constituent parts undertook a preliminary investigation of the validity of these charges, including the taking of information from Mr. Fisher. In fact, I did some of that myself, personally.

In addition, the responsible personnel officer of the Federal Security Agency went to the House committee, Mr. Harness' committee and the Un-American Activities Committee, and had opportunity to consult the files.

All of the evidence or information thus accumulated was brought to the attention of the Acting Commissioner of Social Security and the Federal Security Administrator. The evidence that was available from all of those sources did not persuade the agency that Mr. Fisher was guilty of the charges made or implied against him.

The Federal Security Administrator nevertheless arranged to have a complete investigation of the man made, referred the matter to the appropriate body, I think it is called the Loyalty Board, to make a careful investigation. I forget the details at this point. I am not reading from any document.

At any rate, it was then referred to the Civil Service Commission, and then went to the FBI. The Federal Bureau of Investigation undertook a complete, comprehensive investigation of the matter and has been making such investigation. They have not yet reported back to the Agency the results of their investigation.

Consequently none of us is in position or would wish to prejudge the results until that investigation is completed. I think, however, that it should be stated for the record, since Senator Donnell has brought into the record these quotations from the Harness report, that there was a preliminary investigation of the matter made at once by the Agency and arrangements were entered into as quickly as possible to have a careful and complete investigation made by the FBI, and that the Agency has suspended judgment in the matter until a full record of the facts is available.

I thought with your permission, Mr. Chairman, that these matters should also be made of record, since the charges from the Harness committee have been introduced.

(Subsequently Mr. Falk addressed Senator Smith as follows:)

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
BUREAU OF RESEARCH AND STATISTICS,
Washington, D. C., March 29, 1948.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health, Committee on Labor and Public Welfare, United States Senate, Washington, D. C.

DEAR SENATOR SMITH: At the hearings on January 27, 1948, before the Subcommittee on Health, the charges presented in the Harness report (H. Rept.

No. 786, 80th Cong., 1st sess.) against Mr. Jacob Fisher, a member of the staff of this Bureau, were brought into the discussion. This subject begins on page 249 of the stenographic transcript. You then permitted me to record what the Federal Security Agency had done with respect to those charges against Mr. Fisher. The account ended with my statement that the case was in the hands of the Board of Inquiry on Employee Loyalty of the Federal Security Agency, which was awaiting the results of an FBI investigation.

On March 24, 1948, we received the report of the Board of Inquiry. In order that the record of this case in your hearings of January 27, 1948, may be made complete, I would like to suggest that the following note be added to the record at the end of my statement on this subject (following the third paragraph, p. 254 of the stenographic transcript):

"Subsequently Mr. Falk addressed a letter to Senator Smith, chairman of the subcommittee, adding the following: 'The results of the investigation in this case became available subsequent to this hearing. The Board of Inquiry on Employee Loyalty, Federal Security Agency, which had the results of an FBI investigation, reported on March 24, 1948, that the evidence received by it does not warrant the filing of charges of disloyalty against Jacob Fisher, that it had recommended to the Administrator that the case be closed, and that the Administrator has approved this recommendation and closed the case.' "

I hope that this can be inserted in the galleys or can be added as a footnote when the hearings are in page proof.

Sincerely yours,

I. S. Falk, *Director.*

Senator Smith. You have made that statement to explain the other side of the matter and what you are doing to investigate.

Senator Donnell. Mr. Chairman, I would like to offer at this time also the letter of June 30, 1947, from Mr. Harness, chairman of the committee to which Mr. Falk has referred, which appears in this document, House Report No. 786, and reads as follows:

Washington, D. C., *June 30, 1947.*

Hon. Tom C. Clark,
Attorney General of the United States,
Department of Justice, Washington, D. C.

Sir: There is transmitted to you, herewith, a copy of the interim report of the Subcommittee on Publicity and Propaganda of the Committee on Expenditures in the Executive Departments, for your consideration and appropriate action.

It is the opinion of the subcommittee, from the evidence considered by it at public hearings, that there have been violations of sction 201 of title 18 of the United States Code, by employees of the departments and agencies specifically mentioned in the report. It is suggested and recommended that action be taken by the Attorney General of the United States to prosecute these violations and to prevent further disregard by Federal employees and agencies of the law cited.

The hearings and evidence adduced by the subcommittee are available and will be supplied to the Department of Justice upon request.

I have the honor to remain,

Yours very truly,

Forest A. Harness, *Chairman.*

Mr. Falk. May I interrupt, Senator? I wonder, Mr. Chairman, whether you would also regard as appropriate then to add in the record the letter addressed by Mr. Watson Miller, then the Federal Security Administrator, to Mr. Harness, and which appeared in the Congressional Record, appendix, page 4142, and following.

Senator Donnell. What is the date of that letter?

Mr. Falk. The date of the letter is July 11, 1947. It appears in the Congressional Record for July 26.

Senator Donnell. There is no objection on my part.

Mr. Falk. With that there is, I believe, something further from Mr. Harness. I don't remember offhand whether there were further exchanges of communications, and my secretary advises me there were not, but I thought if a piece of the record is there, it might be well to have all of it in so far as these are public documents.

Senator SMITH. You are offering the exchange of communications from both sides, is that correct, Mr. Falk?

Mr. FALK. Senator, I am not sure as to what I have here, but what I am suggesting, Mr. Chairman, is that in addition to the Harness report which I believe is already in the record of these hearings, introduced in June or July, and these excerpts from it which Senator Donnell has read into the record, there also be in the record the letter or letters exchanged between Congressman Harness and Mr. Miller on this same matter.

Senator SMITH. They will be admitted.

Mr. FALK. I will be glad to identify them more accurately for the clerk later, if I may.

Senator PEPPER. You are handing them to the reporter, are you?

Mr. FALK. I am not sure what I have got, Senator, unless I took a few moments. I think I have them all here.

Senator DONNELL. If Mr. Falk finds some others, there is no objection.

Senator SMITH. I think it is proper to have the interchange of correspondence appear in the record, so that we may have the whole story.

Mr. FALK. It doesn't need to deal with any extraneous matters, but I refer to such matters as Mr. Jacob Fisher and the charges against him.

Senator DONNELL. There is no objection.

Senator SMITH. It will be admitted.

(The documents referred to are as follows:)

[From the Congressional Record, July 26, 1947]

FEDERAL SECURITY AGENCY,
Washington, July 11, 1947.

Hon. FOREST A. HARNESS,
House of Representatives, Washington, D. C.

DEAR CONGRESSMAN HARNESS: As you know from the conversation we had with you on June 17, Mr. Mitchell, the Acting Commissioner for Social Security, and I were greatly disturbed by your criticism, in a speech on the floor of the House on the 16th, of our proposed study of social security in New Zealand. I regret that I was not afforded an opportunity to provide you with the facts which follow before your speech was made.

You had been correctly informed that we had planned to send a member of our staff, Mr. Jacob Fisher, to New Zealand. However, he was not being sent merely or even primarily "to study compulsory health insurance in that country" as was stated in your speech but to study the whole social security system. Mr. Fisher's inquiries on health benefits were to be only a fraction of a broad social security study which was planned to include cash benefit provisions for old age, invalidity, unemployment, sickness, widows, orphans, minors, etc.

The New Zealand Social Security System is recognized among experts as being of great significance on account of its unified nature, comprehensive scope, and other special characteristics. It is different in many important respects from our own and from the systems of most other countries. It combines social insurance and public assistant concepts in unusual ways, its coverage is national, the protections are very broad, and the financing rests on earmarked national income taxes. It has attracted world-wide attention, and is widely regarded as something in the nature of a laboratory experiment for testing many important and controversial proposals in the field of social security. It has been criticised by some insurance and medical writers as a bad and overambitious program that cannot succeed; and at the same time it has been held out, in a report from the Brookings Institution of Washington, as something of a model for a new type of social security program for the United States. Obviously, it cannot be all that is claimed or charged. We have learned all that we could about it through published documents, correspondence and personal inquiries here. Though we have had every courtesy and assistance from the New Zealand representatives in Washington and by correspondence from officials in New Zealand, many questions about administration, effectiveness of the system, costs, etc. have remained unanswered; and some conflicting reports have been left unresolved. Study and inquiry on the ground were, in our opinion, clearly indicated.

Mr. Fisher had already made careful studies of all the available information on the New Zealand system, with the assistance of other technical experts on our staff. As far as we know, his two publications on this subject[1] have been received—both here and abroad—as accurate, objective, and authoritative documents. He was therefore selected for this new investigation. In your speech to the House you said that his "report on socialized medicine * * * has been described by several reputable authorities as extremely biased and dishonest." In this connection may I say, first, that Mr. Fisher's article did not deal with socialized medicine. It described the New Zealand system of cash and health benefits. Secondly, no comments such as those you referred to have come to our attention. I trust that the sources of this criticism may be made known to us in order that we may learn the basis for the charges.

Your speech referred to this trip to New Zealand as a type of activity "never authorized by Congress" and "never * * * authorized directly or indirectly in the appropriation bills." While you reiterated this view during our discussion in your office, I presume that any confusion which may have existed on that subject has now been cleared up by your committee counsel who has assured us that he has no question as to our authority to engage in this activity or to incur financial obligations in connection with it. His opinion in this respect conforms to that of the legal staff of this agency.

The Social Security Act (sec. 702) imposes a positive "duty" upon this agency for engaging in activities such as the one regarding which you have raised question. This duty to make studies and recommendations has always included studies of foreign as well as domestic practices and experiences. Indeed, you will find that foreign systems, and the lessons to be learned from them, were carefully and extensively considered by the House and Senate Committees when social security legislation was first enacted, just as they have been on various occasions since then when committees of Congress have considered changes in the social security laws. All countries have a great deal to learn from each other about social security, from both successes and failures, and this has always been the attitude of Congress. I have not the slightest doubt that congressional committees would regard us as having done less than our duty under the law if they found, at hearings or on other occasions that we had not taken all reasonable steps to be informed on foreign experience.

Since you have raised questions and expressed disapproval of our selection of Mr. Fisher for the New Zealand study, and since I have high regard for the wishes of Members of Congress and its committees, and acknowledge our responsibility to them, I have directed that the study be postponed until after our investigation of the charges against him is completed.

While I expect to go into the matter thoroughly the data obtained thus far from your committee counsel, from the House Committee on Un-American Activities and from Mr. Fisher himself impress me as not justifying so serious a reflection upon the reputation of a person whose conduct and service, so far as we have been able to observe, have been beyond reproach.

In view of the fact that your criticism of this Agency and certain of its programs and officers has been made a public record, I trust that you will similarly make this letter a public record.

Sincerely yours,

WATSON B. MILLER, *Administrator.*

JULY 24, 1947.

HON. WATSON MILLER,
Administrator, Federal Security Agency, Washington, D. C.

DEAR MR. MILLER: I desire to acknowledge your letter of July 11, 1947, regarding the remarks I made on the floor of the House on June 16. In the speech to which you refer, and at a conference held with you and Mr. Mitchell in my office on

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[1] Cash Benefits Under the New Zealand Social Security Program, Bureau of Research and Statistics Report No. 13, June 1945; 42 pp.; the New Zealand Social Security Program, Social Security Bulletin, September 1945, vol. 8, No. 9, pp. 3–11.

June 17, I definitely expressed my disapproval of international junkets by Federal employees. I refer to trips designed to make studies of foreign concepts of government to further the plans and ideologies of groups in this country to influence legislation being considered by the Congress of the United States; and I reiterate I am today strongly of the same opinion.

I have made careful study of the memorandum submitted by Isidore Falk, Director of the Bureau of Research and Statistics, entitled, "New Zealand Social Security Plan: Principal Features, Aspects Warranting Field Study." Under "Principal Features," it is stated:

"New Zealand Social Security Plan is of interest to the rest of the world because it ties up in one package protection against all of the major risks to income, 'free' medical care, complete population coverage, pay-as-you-go financing."

The list of subjects given in the memorandum to be studied, most of which relate to Compulsory Health Insurance, are of such nature that I feel they could be secured without great expense to the Government; and that travel to the far corners of the globe is unwarranted, as well as unauthorized.

The Subcommittee to investigate publicity and propaganda (of which I am Chairman) does not concern itself with the merits of pending legislation but is interested in the subject of improper and unlawful activities of Federal employees attempting to influence the Congress for or against pending legislation.

In view of your reference, I should like to direct your attention to Relief and Social Security, written by Lewis Meriam, and published by the Brookings Institution, in 1946, in which there is some criticism of the New Zealand plan; and I refer, particularly, to language contained on page 548, which reads as follows:

"The New York Times of October 7, 1945, reported that the Minister of Health of New Zealand had stated in the house of representatives that because of abuses the Government is seriously considering whether free physician services will be continued. It admits widespread racketeering which followed the institution of a system under which a New Zealander may consult a physician as frequently as he likes, and the doctor can collect a fee for each visit. The costs are running far higher than the Government had anticipated when it instituted the system, and they constitute a serious drain on the social security fund. Placing physicians on salary is one of the possibilities under consideration."

Certainly, the language above-quoted, taken from the report of the Brookings Institution, would not justify the New Zealand plan as being a model which might be adopted by the United States Government.

In my speech on the floor, reference was made to articles written by Jacob Fisher. In your letter of July 11, 1947, you stated that "Mr. Fisher's article did not deal with socialized medicine. It described the New Zealand system of cash and health benefits."

The coverage given medical care in Mr. Fisher's article, The New Zealand Social Security Program, most certainly presents a picture of socialized medicine.

Four of the five paragraphs in the introduction deal with New Zealand's health benefits program.

The second section of the article is headed "Health Benefits" and devotes nine columns to the subject with subsections on "Medical benefits," "Hospital benefits," "Maternity benefits," and "Other benefits." "Other benefits" are divided into "Pharmaceutical," "X-ray," "Massage," and "District nursing." The next section in the article is tilted and deals with "Relationships with the medical profession."

The following subtitle "Relative success in attaining goals" begins with this paragraph—"To what extent has the health program achieved its objective—elimination of ability to pay as a factor in the distribution of medical care?"

It is a well-known fact that elimination of ability to pay as a factor in the distribution of medical care has been a favorite argument by proponents of socialized medicine.

Two days prior to writing this letter to me, you testified before the United States Senate Subcommittee on Health of the Committee on Labor and Public Welfare. The record of the hearing of July 9, on page 1723, reveals that Senator Donnell made inquiry as to the books and pamphlets you had read on the subject of social security programs of other countries. I quote briefly from the record:

"Senator DONNELL. You have not read any books, as distinguished from pamphlets, on the subject of compulsory health insurance, either in England or in Germany?

"Mr. MILLER. No extensive documents.

"Senator DONNELL. How about New Zealand? Have you read the experience of New Zealand with compulsory health insurance?

"Mr. MILLER. I have not."

It is apparent, therefore, from your sworn testimony that, although you have outlined at length the New Zealand Plan and referred to Mr. Fisher's article, you are, in fact, without knowledge of the New Zealand Plan or the content of Mr. Fisher's article. Therefore, in view of your testimony, I feel further reference to the New Zealand Plan or the Fisher article is unnecessary.

You have stated that counsel for my Committee has assured the FSA that he has no question as to its authority to engage in this activity or to incur financial obligations in connection with it. Mr. Bow, who is counsel for the Committee, has advised me that no such advice has been given by him to the Federal Security Agency, or any other department or agency of Government. Mr. Bow recalls that, at the time of the Hearings on the Health Workshop, inquiry was made of him regarding any prohibition by statute, relating to foreign travel. Mr. Bow's reply was that, at that time, he could cite no prohibiting statutes nor statutes authorizing the travel; and he suggested that, as counsel for the committee, further study would be made of the subject. The subcommittee counsel study does not conform with that of the legal staff of your agency.

Section 702 of the Social Security Act, reads as follows:

"DUTIES OF THE ADMINISTRATOR

"SEC. 702. The Administrator shall perform the duties imposed upon him by this act and shall also have the duty of studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation, and related subjects."

The history of the enactment of this law is interesting, anl I shall refer to it only briefly. The Social Security Act was recommended by the President to the Congress on January 17, 1935. On the same day, there was introduced in the Senate, Senate Bill 1130; and, in the House, H. R. 4120.

Each of the proposed bills contained a section, "Duties of the Social Insurance Board," which stated that the Board should, among its other duties, have the "duty of studying health insurance." However, the bill was rewritten and reintroduced as H. R. 7260, on April 4, 1935; and the provision, "duty of studying health insurance," had been eliminated; and the bill, as amended, became law on August 14, 1935.

It is apparent, therefore, that the Congress of the United States, by the elimination of the authority to study health insurance, intended that the agency, under the Social Security Act, should not engage in such studies. Such an interpretation is elementary in the field of statutory construction, and I shall not burden this letter with further comment upon the question of proper construction. However may I say that there is serious question as to the authority of the Federal Security Agency to conduct the study of health insurance.

In view of the foregoing, I repeat my statement made on the floor of the House, to which you have made reference:

"These international junkets are an item of considerable expense. Such activities have never been authorized directly or indirectly in the appropriation bills."

That the attitude of Congress on foreign studies was known to the Federal Security Agency is obvious from an interoffice communication dated April, 1947, from Maurine Mulliner to Mr. Falk and others, which reads as follows: "Subject: Project to Study Social Security in Other Countries:

"Several questions have been raised during the last 10 days, in considering congressional attitudes with respect to the budget for this administration, about the wisdom of proceeding with the project to study social security in other countries. It is the consensus of those who have commented that nothing further should be done at this time on this project. Consequently, this project is being dropped unless you bureau directors believe that further consideration should be given to it."

You further state in your letter that the information which you have thus far received does not justify so serious a reflection upon the reputation of Mr. Fisher. This is a charge I cannot permit to remain unanswered, for it is again obvious that those upon whom you rely have withheld facts from you, or have distorted facts to which you were entitled. I have seen Jacob Fisher's report to Mr. Isadore Falk, dated June 17, 1947, relative to his investigation of the published volumes of the Un-American Activities Committee. If the accuracy of his investigation in this matter is any criterion upon which his ability might be tested, I am sure that further study or investigation by the individual should not be considered or contemplated.

Mr. Fisher failed to mention the magazine, "Social Work Today" (of which he was managing editor and a member of the board of editors). In the reports of the Special Committee on Un-American Activities, the following comment relating to Mr. Fisher's magazine will be found

"A study of the contents and policies of the magazine (Social Work Today) indicate, however, that it is primarily a vehicle whereby the line of the Communist Party is promulgated among social workers in a form calculated to be most palatable and effective to this particular group.

"Social Work Today has been the vehicle for considerable publicity in behalf of numerous front organizations supporting the line of the Communist Party.

"Social Work Today has been quick to respond when individual Communists are under fire.

"In 1935, the magazine was sponsored by the National Coordinating Committee of Rank and File Groups in Social Work, an organization of left-wing social workers."

Jacob Fisher was the chairman of the National Coordinating Committee of Rank and File Groups in Social Work, from its inception.

I am attaching to this letter a report submitted to me by the staff of my subcommittee. It is too lengthy to be the subject of this letter; but I am sure that, after you have given consideration to the evidence in the report, you will understand my anxiety in this matter and why I called it to the attention of the House of Representatives. It would seem your duty in the matter is, also, well defined.

You have asked that your letter be made a public record; and I am pleased to comply with your request, by asking that it be printed in the CONGRESSIONAL RECORD, together with this, my reply.

Sincerely yours,

FOREST A. HARNESS,
Chairman.

Attachment: Staff report.

To: Hon. FOREST A. HARNESS, chairman, Subcommittee on Publicity and Propaganda of the House Committee on Expenditures in the Executive Departments.
From: Committee Staff.
Subject: Jacob Fisher.

REFERENCES

We are in receipt of the following applications filed by Jacob Fisher for positions with the Social Security Board of the Federal Security Agency:

Social Security Board, dated June 30, 1936.

United States Civil Service, dated September 1, 1938.

Federal Security Agency, dated June 19, 1940.

Without exception the individuals given as references, by Jacob Fisher, in these applications, are found in the published reports of the Special Committee on Un-American Activities (Dies committee).

The references given by Jacob Fisher are:

June 30, 1936: Mary van Kleeck, Herbert D. David, Simon Breines, Albion W. Hartwell, George Wolfe.

September 1, 1938: Mary van Kleeck, Harry Greenstein, George Wolfe, Maurice Bernstein, Morris Lewis.

June 19, 1940: Philip L. Klein, Mary van Kleeck, Harry Greenstein, Louis Sobel, Morris Lewis.

The mention given in the published reports of the Special Committee on Un-American Activities (Dies committee) range from a single mention for Herbert D. Davis, who is listed as the signer of a statement defending the Communist Party, to Mary van Kleeck, who "has a long list of connections with front organizations and movements dominated by the Communist Party" (Report on the National Citizens Political Action Committee, p. 918).

ACTIVITIES OF JACOB FISHER

He was a member of the executive committee of the New York chapter of the Interprofessional Association which was also the Provisional National Executive Committee of the Interprofessional Association.

(Jacob Fisher was elected to this membership at the meeting of the organizing group on March 24, 1934.) He later appears as a member of the national executive committee.

The Interprofessional Association was later known as the Interprofessional Association for Social Insurance.

The Interprofessional Association and the Interprofessional Association for Social Insurance cooperated closely with various Communist-controlled front organizations; received favorable publicity in the Daily Worker (official publication of the Communist Party); and carried on their activities in close cooperation with leaders of the Communist Party.

He was secretary of the Interprofessional Association for Social Insurance. His name appears on the letterhead of a letter sent by Mary van Kleeck, chairman of the association and chairman of the provisional committee for National Congress for Social Security, which accompanied a "Call to a National Congress for Unemployment and Social Insurance."

"Herbert Benjamin, member of the National Committee of the Communist Party in the United States, general secretary-treasurer of the Workers Alliance, and later executive secretary of the International Workers Order, was executive secretary of the national sponsoring committee for the National Congress for Unemployment and Social Insurance. Among the other avowed members of the Communist Party who served on this committee were the following: Max Bedacht, William Z. Foster, Granville Hicks, Lem Harris, Israel Amter, Earl Browder, Ben Gold, Roy Hudson, Elmer Johnson, Fred Biedenkapp, Benjamin Davis, Jr., Harold Hickerson, George Primoff, Grace Hutchins. The foregoing names tell an accurate story of the National Congress for Unemployment and Social Insurance. Its completely Communist character was not even thinly veiled" (p. 1183, Report on the National Citizens Political Action Committee).

He was a member of the executive committee of the Social Workers Committee to Aid Spanish Democracy. "This committee was one of the numerous Communist fronts which were set up for agitation around the issues of the Spanish civil war" (p. 1577, Report on the National Citizens Political Action Committee).

He was one of the endorsers of the Campaign to Aid International Volunteers. The campaign was a project of the Communist-controlled North American Spanish Aid Committee. Almost all of the other endorsers were persons whose names will be found on the lists of numerous Communist-front organizations.

He was one of the endorsers of an emergency Conference for the Release of International Volunteers in Spanish and French Prison Camps, held April 13, 1940, Hotel Capital, New York City. Some of the other endorsers were the Honorable Vito Marcantonio, Dr. Edward Barsky, Herman Shumlin, Marcel Sherer (see the Congressional Record, May 21, 1941, p. 1388), Rockwell Kent, and Sam Wiseman, of the Workers Alliance. (Appeared in Daily Worker, March 25, 1940.)

He was a sponsor of a conference called by the Consumers' National Federation. In 1939, Earl Browder identified the Consumers' National Federation as a "transmission belt." A "transmission belt" is described by the Special Committee on Un-American Activities as being "In Communist nomenclature, an organization through which the Communist Party extends its influence and ideology to groups which are broader than the party (Communist Party) itself." Among the other sponsors are found such well-known Communists as Israel Amter, Grace Hutchins, Rose Nelson, and Bella V. Dodd.

He was one of the individual sponsors of a campaign to raise funds for the Disabled Veterans' Fund launched by the Friends of the Abraham Lincoln Brigade, which was completely controlled by the Communist Party as indicated by the report of Earl Browder, General Secretary to the National Committee of the Communist Party on May 6–8, 1939.

He was active in the Rank and File Movement of social work groups. The Rank and File Movement was originally composed of other than professional social workers. The Rank and File Movement began with discussion clubs of which the New York Discussion Club was among the most active. The program followed by the discussion clubs paralleled the program of the Communist Party. There was an interlocking between the discussion clubs and the Inter-Professional Association (later the Inter-Professional Association for Social Insurance). Communist Party leaders were active in many of the undertakings of the afore-mentioned groups. At the first national convention of Rank and File Groups in Social Work, Jacob Fisher was elected chairman of the National Coordinating Committee of Rank and File Groups in Social Work. In April of 1936 the name was changed to the National Coordinating Committee of Social Service Employee Groups and Jacob Fisher continued as chairman. A month after the first national convention and the formation of the National Coordinating Committee of Rank and File Groups in Social Work with Jacob Fisher as chairman, rank-and-file social-work employees began work stoppage, mass demonstrations, picketing, and general demonstration activities. "It was in New York that the mass meetings, petitions, publicity, delegations, demand for collective bargaining by social workers was first engaged in.

The rank-and-file groups lent support to other groups and affiliated themselves with a series of Communist Party cause célèbre, such as the Angelo Herndon case, the Scottsboro boys, the department store strikes, the Newspaper Guild strikes, defense of David Poindexter, and similar activities. The 1936 convention of the National Coordinating Committee was opened with greetings from the National Unemployment Council, a completely Communist-controlled group, and the Workers' Alliance of America, which was also dominated by the Communist Party.

The official publication of the Discussion Clubs and the NCC was "Social Work Today." Jacob Fisher was the first editor. As in the case of his references, mentioned at the beginning of this report, every one of the contributing editors in the first few issues are found in the published reports of the Dies Committee. Harry L. Lurie, Jacob Fisher's last supervisor before he was employed by the Federal Security Agency, was active with the above-mentioned group and is given considerable mention in the published reports of the Dies Committee. The report on "Social Work Today" follows.

Jacob Fisher given as editor and/or one of a group of editors in the following issues of Social Work Today:

Jacob Fisher, sole editor, volume 1, Nos. 1, 2, and 3, 1934.

Jacob Fisher and three others listed as editors, October 1934 through July 1935, seven issues.

Jacob Fisher and two others listed as editors, volumes 4 and 5, October 1936 through June 1937.

ACTIVITIES

Social Work Today, Publication of the Social Workers Discussion Club of New York.

March–April 1934, volume 1, No. 1: Editor, Jacob Fisher (p. 9).

Page 19: Advertisement. There is only one advertisement in this issue. It reads as follows:

"INFLATION DOES NOT AFFECT YOUR TRIP TO THE U. S. S. R.

" 'Full value of your dollar.'

"Special group sailings to the Soviet Union for the May Day celebration. Arrangements are now being made for 'special worker,' student, and teacher groups to the Soviet Union during the spring and summer. Our long and thorough experience warrants you the best service.

"Torgsin orders sent through us are executed by mail or cable 'at the lowest rates.'

"World Tourists, Inc., 175 Fifth Avenue, New York City. Telephone ALgonquin 4–6656–7–8.

" 'Excursion boats and buses chartered for organizations at lowest prices.' "

(NOTE.—The single-quoted portions above are in italics in the advertisement.)

Pages 3, 4, 5, and 6: Article describing the convention of the American Association of Social Workers which was held at the Mayflower Hotel, Washington, D. C., early in 1934. The following are excerpts from the article:

Page 4: "Social workers must realize that it is terribly important to get behind the whole economic program of the President. As for him, he has appointed his last right winger! [Applause.] From now on he will appoint only people sympathetic with that program."

Page 5: "Fisher of New York suggests there are other measures before Congress. But first he would like to propose three principles. One, that insecurity can be corrected only by redistributing income. Two, that good-will and intelligence won't put through any program that runs counter to the interests of any control group. The most effective pressure for social change comes from the group that will benefit—in the case of unemployment insurance, labor itself. The best social workers can do is to get behind the pressure group. Three, wealth is distributed unevenly geographically and a Federal program alone can do the job."

May–June 1934, volume 1, No. 2: Editor: Jacob Fisher (p. 2).

Page 9: Article by Jacob Fisher, Social Work and Liberalism. Opening sentence: "American social work is an integral part of the liberal's answer to life under capitalism."

July–August 1934, volume 1, No. 3: Editor: Jacob Fisher (p. 2).

October 1934, volume 2, No. 1: Editors: Flora Davidson, Jacob Fisher, Clara Miller, Elizabeth Ruth Sherman (p. 2).

November 1934, volume 2, No. 2: Editors: Same as above (p. 2), Jacob Fisher and three others.

Page 12: Article by Jacob Fisher, Do Strikers Get Relief? with picture of southern textile strikers picketing (p. 13); two pictures of police brutality (p. 14).

January 1935, volume 2, No. 3: Editors: Same as above (p. 2), Jacob Fisher and three others.

February 1945, volume 2, No. 4: Editors: Same as above (p. 2), Jacob Fisher and three others.

Page 8: Article by Jacob Fisher, Meet the Relief Administration. This article is an account of the Unemployed Council delegation led by Israel Amter, on a visit to Aubrey Williams, Assistant Administrator of F. E. R. A. This two-page article is typical of the agitation technique which was carried on in the year 1935 by the communist, communist-front and fellow-traveler groups. The phraseology of the article eliminates any doubt as to the author's pro-communist leanings.

Back cover: An apt description of the publication Social Work Today is given on the back cover of this issue:

"Social Work Today is the voice of social workers who * * * realize that they must become the allies of labor in the struggle for a new social order" (Pen and Hammer Bulletin, organ or revolutionary writers' group, quoted on back cover, Feb. 1935 issue).

"The well edited Social Work Today * * * has effectively represented the radical wing of the social workers * * *" (From The Nation. This item appears on the back cover of the Feb. 1935 issue.)

April 1935, volume 2, No. 5: Editors: Jacob Fisher and three others (p. 2).

Pages 5, 6, 7, and 8: Article by Jacob Fisher, Rank and File Challenge—First National Convention of Rank and File Groups in Social Work.

Page 8: Jacob Fisher was chairman of the arrangements committee for the convention, and was elected Chairman of the National Coordinating Committee of Rank and File Groups in Social Work, which was set up at the convention.

October 1935, volume 3, No. 1: Article by Jacob Fisher, Threat to the Relief Workers. This article deals with the program of action engaged in by the various groups affiliated with the National Coordinating Committee, of which Jacob Fisher was Chairman, and their program for bringing pressure to bear on Aubrey Williams and the F. E. R A. administration.

February 1936, volume 3, No. 5: Article by Jacob Fisher, The Rank and File Movement 1930–1936.

Pages 5 and 6: Precedent for protective organization already existed in private social work. The New York Association of Federation Workers, organized in 1931 to promote the economic interests of employes of agencies deriving their support from the Jewish Federation of that city, had done considerable spadework in the theory and practice of protective organization. It was this New York group which first defined the employer-employee relationship in social work, first developed the techniques of mass meetings, petitions, publicity, the support of other groups, delegations, and first raised the demand for collective bargaining. It was this group which later engaged in the first stoppage in social work history.

Page 18: Social Work Today addressed letters to a group of representative individuals requesting a brief statement of their views on the use of demonstrations, picketing and stoppage in social work.

One of the replies was by Ewan Clague. Excerpts from that reply are:

Page 18: "Under such circumstances it seems to me essential that social workers should organize themselves into efficient, coordinated groups. I think this will be the best, if not the only, effective way to protect themselves and their work."

"In dealing with the Government it is impossible to use the more aggressive tactics that are used on a private employer. Perhaps it is unfortunate that this is so, but the fact remains that such action against the Government is always interpreted as being directed against the public as a whole. Any politician can cry 'subversive,' 'revolutionary,' 'communistic,' and easily persuade the public that concerted action by a group of Government employees is a threat to the general welfare. Even the most militant trade-unions have refrained from aggressive, open warfare against a Government agency.

"Social workers will never enjoy the full confidence of the community until they have demonstrated that they are doing a skilled job requiring special training and experience. So long as a considerable section of the public, along with many of the cheap politicians, believe that the only necessary requirement of a social worker is 'common sense' and that unpaid, volunteer service is better than professional service, just so long will social workers be ineffective, no matter what tactics they attempt. Therefore, I would counsel centering attention upon this one point, perhaps to the exclusion of most others, and hammer upon it by the most effective means at our disposal. This, to my mind, would constitute the best tactics at the present time."

(NOTE.—The first contact made by Jacob Fisher for a position with the Federal Security Agency was a letter to Ewan Clague (See SSA Jacob Fisher personnel file). Ewan Clague, formerly with SSB, is now Director of Labor Statistics of the Bureau of Labor Statistics, Department of Labor.)

April 1936, volume 3, No. 7, paragraph 11: At a convention of the National Coordinating Committee in Cleveland, Ohio, February 22 and 23, 1936, the name was changed to the National Coordinating Committee of Social Service Employe groups. Jacob Fisher continues as chairman.

Page 11: Article by Jacob Fisher, The AASW Takes Its Stand, "Good, But Not Good Enough." This is a report on the 1936 Delegate Conference of the AASW held in Washington, D. C., Feb. 14–16, 1936.

November 1936, volume 4, No. 2, page 27: Under "Books in Review" is a review by Esther Lucille Brown of a book by Jacob Fisher entitled "The Rank And File Movement In Social Work," a 49-page pamphlet published by the New York School of Social Work. In the review Esther Lucille Brown states "this is the story that Mr. Fisher tells of the period from 1931–1933 when a group of courageous young persons became so dissatisfied with the social order or their own economic status or both that they proposed to 'do something about it.'"

April 1937, volume 4, No. 7, page 3: Editorial entitled "We Support the President." Some excerpts from this are as follows:

"Social Work Today calls upon all social workers to lend unqualified support to the President's plan to enlarge the Supreme Court because:

1. It will remove the threat of judicial veto hanging over the activities of the Social Security Board, the Tennessee Valley Authority, the Public Works Administration, and the Labor Relations Board.

"2. It will do so immediately avoiding the lengthy process of reform thru constitutional amendment.

"3. It is clearly constitutional.

"4. It will bring the federal judiciary in line with the overwhelmingly progressive sentiment of the country.

"We may well remind the first group (the manufacturers association) that there always has been politics in the Court. The question is not politics or no politics, but what kind of politics? Whose political aspirations shall be honored, those of the sweat-shop manufacturer, or those of the working population?"

May 1937, volume 4, No. 8, page 3: Article by Jacob Fisher "It Just Doesn't Belong!" supporting the viewpoint that trade-unionism belongs in the professional field of social work.

October 1937, volume 5, No. 1, page 8: Article by Jacob Fisher, Forward With the CIO.

This is a report on the birth of the United Office & Professional Workers of America, a CIO international union. It was formed chiefly from local unions previously members of the A. F. of L. The United Office & Professional Workers of America issued charters to four social service locals, one of which was the Social Service Employes Union of New York which became Local 19, UOPWA.

Page 30: Under a column headed "Shop Talk" appears the following item:

"Jacob Fisher and Daniel Allen (Forward With the CIO and CIO, for Public Agencies) are leaders in the converging lines of public and private agency employees into the CIO. Mr. Fisher is President of the Social Service Employees Union of New York, Local 19, United Office & Professional Workers of America.

Mr. Allen is New York District Organizer for the State, County and Municipal Workers of America."

November 1937, volume 5, No. 2, page 30: In a column headed "Shop Talk" under a subheading "At the New York State Conference" appears the following:

"Delegates and visitors to the New York State Conference of Social Work are to be offered two interesting sessions sponsored by the Joint Trade Unions in Social Service in New York City. On October 20th, Jacob Fisher, New York SSEU President, will preside at the first session entitled 'Unionism and Professionalism'."

Page 31: In an advertisement of the Social Workers Committee to Aid Spanish Democracy—For Child Welfare—soliciting funds for children in Republican Spain, Jacob Fisher's name appears as a member of the executive committee of this organization.

December 1947, volume 5, No. 3, page 18: Article by Jacob Fisher, Private Agency Annuity Plans. The New York Social Service Employes Union, of which he is president, evaluates 11 existing annuity plans and recommends inclusion under the Social Security Act.

Page 30: Under a column headed "Shop Talk" appears the following: "Jacob Fisher (Private Agency Annuity Plans) is one of our first, best, and most faithful contributors."

January 1938, volume 5, No. 4, page 15: Jacob Fisher is listed under the 1936–37 Social Work Today Cooperators as having contributed $20 in the preceding 12 months to the support of the magazine.

March 1938, volume 5, No. 6, page 29: In the section, Books In Review, Jacob Fisher does a review of the book, When Clients Organize, by Helen Seymour. Among his comments are:

"Judging from the growing concern of the CIO and Labor's Non-Partisan League with unemployment, with relief and social insurance, that future (of the organized client movement) may lie perhaps with the economic and political organization of labor rather than with client organization as we have known it in the past."

June 1938, volume 5, No. 9, page 21: Article by Jacob Fisher, One Year of the CIO in Social Work.

In this he reviews the activities of the past year of the State, county, and municipal workers of America and the United Office and Professional Workers of America and their respective locals in the field of social service.

He reports that the New York Local, Local No. 19, the Social Service Employes Union, sent delegates to the American Youth Congress in Milwaukee. Jacob Fisher was President of Local 19 at that time.

Page 46: Under "Shop Talk" is the following item: "Jacob Fisher is president of Social Service Employes Union, Local No. 19 of UOPWA, CIO, New York City."

December 1938, volume 6, No. 3, page 25: The following item appears in a box headed "The Profession Is Proud."

"On September 16th Jacob Fisher, President of the New York City Social Service Employes Union, was elected a vice-president of New York State's new CIO Industrial Council. Thus one of the early leaders of the trade Union movement in social work has been given the responsibility of representing the white collar and professional workers who constitute an important section of the 800,000 CIO members in the State."

January 1939, volume 6, No. 4, page 17: Under the heading "Social Work Today Cooperators—1938" and the sub-heading "New York City" Jacob Fisher is listed as having contributed $10 to the magazine Social Work Today during the year 1938.

April 1939, volume 6, No. 7, page 9: Article by Jacob Fisher, President, Local 19, Social Service Employes Union, UOPWA, entitled "The Future of the Private Field."

May 1939, volume 6, No. 8, page 27: Under the column heading "Trade Union Notes" and the sub-heading "Joint Trade Unions at Buffalo" is the program of the Joint Committee of Trade Unions in Social Work at the Buffalo National Conference June 18–24. Among the various items is the following:

"Jacob Fisher, President, SSEU Local 19, is to speak on 'Social Work and the Democratic Tradition'." (This was on the program for Thursday, June 22.)

January 1940, volume 7, No. 4, page 17: Under the heading "Social Work Today Cooperators—1939" and sub-heading "New York City" Jacob Fisher is listed as having contributed $15 to the magazine Social Work Today during the year 1939.

Pages 5 and 6: Jacob Fisher is one of the 75 national and local leaders in social work who signed a statement of principles that was prepared by the editorial board of Social Work Today. This appeared under the heading, "Meeting social need: A peace program." The statement of principles was against America being geared into a military program; was against military preparation; advocated taxing all the profits out of those industries supplying war materials; advocated peace and was against involvement in the European war. This statement of principles was released to the press and mailed to every Member of the United States Congress.

April 1940, volume 7, No. 7, page 9: An article by Jacob Fisher, "Relief: Old Problem, New Setting." He is listed as president, New York City Joint Council UOPWA. "With business on the downgrade and legislatures bending to reactionary pressure, the outlook of the unemployed is little short of desperate."

January 1941, volume 8, No. 4, page 5: A reprint of the January 1940 article A Statement of Principles which has Jacob Fisher as one of the 75 signatories.

Page 16: Under the heading "Social work today cooperators—1940" and the subheading "Illinois," Jacob Fisher is listed as having contributed $15 to the magazine, Social Work Today, during the year 1940.

Pages 28–29: Under Books in Review Jacob Fisher does a review of the book "Foundations of American Population Policy," by Frank Lorimer, Ellen Winston, and Louise K. Kiser. It was published by Harper & Bros.

Mr. Jack Fisher's review is an adverse one which he heads up "Control for what?" and in it refers to the "Fascist" mentality from which the authors obtained their ideas of eugenics.

June–July 1941, volume 8, No. 9, page 17: Article by Jacob Fisher, Social Security Board Regional Office, Chicago, entitled "Running Out on the Needy." [A note at the bottom of the page stated: Mr. Fisher writes in his personal capacity. The Social Security Board is not responsible for the views expressed.—Eds.]

This article defended the large relief rolls despite the marked upturn in business activity and prosperity and fought any cuts in relief funds.

February 1942, volume 9, No. 4, page 51: Under the heading "Social work today cooperators—1941" and the subheading "Illinois," Jacob Fisher is listed as having contributed financially to the support of the magazine, Social Work Today, during the year 1940.

FEDERAL SECURITY AGENCY
SOCIAL SECURITY ADMINISTRATION
INTEROFFICE COMMUNICATION
October 6, 1947

To: Mr. A. J. Altmeyer, Commissioner.
From: W. L. Mitchell, Deputy Commissioner.
Subject: Facts with regard to the proposed trip to study the New Zealand social security program and major issues raised by Representative Harness as to the trip and as to past activities of Mr. Jacob Fisher.

The attached notes summarize briefly the facts relating to the major charges and issues which have been raised by Representative Harness with regard to a proposed field trip by Mr. Jacob Fisher, of the staff of the Bureau of Research and Statistics, to study the New Zealand social security system. If you wish further information with regard to any point, we shall be glad to assemble it for you.

W. L. MITCHELL.

NOTES ON MAJOR ISSUES RAISED BY REPRESENTATIVE HARNESS WITH REGARD TO THE PROPOSED TRIP TO STUDY THE NEW ZEALAND SOCIAL SECURITY PROGRAM AND AS TO THE PAST ACTIVITIES OF MR. JACOB FISHER

The first public reference by Representative Harness to the proposed New Zealand study occurred in a speech which he made in the House on June 16 (Congressional Record, June 16, 1947, pp. 7251–7252). In his statement Mr. Harness challenged the right of the Social Security Administration to make a field study of the New Zealand program and charged Mr. Jacob Fisher, the staff member who was to make the field trip, with uninterrupted association since 1939 with Communist-front organizations. The Third Intermediate Report of the Committee on Expenditures in the Executive Departments (80th Cong., 1st sess., H. Rept. No. 786, July 2, 1947, pp. 6–7) also contained a reference to the proposed New Zealand trip and repeated the charges against Mr. Fisher.

On July 11, the Federal Security Administrator, Mr. Watson Miller, wrote to Representative Harness stating the Agency's position with regard to the proposed field trip, indicating that a preliminary investigation had shown no basis for question as to Mr. Fisher's loyalty, and informing the Congressman that the trip was nevertheless being postponed until a complete investigation could be made of his charges against Mr. Fisher. On July 24, Representative Harness replied to Mr. Miller, reiterating and amplifying his previous criticisms of the study and attaching a staff report on Mr. Fisher prepared by the staff of the Subcommittee on Publicity and Propaganda of the House Committee on Expenditures in the Executive Departments. (This letter and Mr. Miller's letter of July 11 were printed in the Congressional Record for July 26, 1947, pp. A 4142–4146.)

An analysis of these documents reveals three major issues or charges, pertinent to this memorandum. They are—

1. The nature and character of the proposed field study of the New Zealand social-security system;
2. The legal authority of the Federal Security Agency and the Social Security Administration to engage in studies of health insurance or to undertake studies in other countries;
3. The alleged Commuist-front associations of Mr. Jacob Fisher.

1. The nature and character of the proposed study

In his June 16 speech, Representative Harness stated that Mr. Fisher was being "sent to New Zealand to study compulsory health insurance in that country." The trip was cited as an example of "the activities of the Social Security Board in this country and abroad, which seek to further the cause of socialized medicine in the United States." "It is a matter of record," the Congressman said, "in the Senate hearings last year on S. 1606, that Mr. Falk was one of the principal authors of the bill presented pursuant to President Truman's national health program. That bill contemplated compulsory health insurance, and embodied every recognized feature of socialized medicine." "He [Mr. Fisher] has published at least one report on socialized medicine in New Zealand, in the Social Security Bulletin—a report which has been described by several reputable authorities as extremely biased and dishonest." "* * * it is not the function of the Federal Government to send people around the world to bring back reports presuming to dictate a system of socialized medicine in the United States."

The Committee report (H. Rep. 786) introduces the reference to Mr. Fisher and the New Zealand trip with a statement that "the Bureau of Research and Statistics in the Social Security Board also maintains close contact with movements for compulsory health insurance in other countries."

Representative Harness' letter of July 24 states that he has studied "the memorandum submitted by Isidor Falk, Director of the Bureau of Research and Statistics, entitled, 'New Zealand Social Security Plan: Principal Features, Aspects Warranting Field Study.'" He goes on to say that the "list of subjects given in the memorandum to be studied, most of which relate to Compulsory Health Insurance," are of such a nature as not to require field study. He questions several statements in Mr. Miller's letter of July 11 with regard to the New Zealand system and Mr. Fisher's Bulletin article (see below for analysis of these points), quotes from Mr. Miller's testimony before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare to prove that Mr. Miller has no personal knowledge of the New Zealand program, and refers to "trips designed to make studies of foreign concepts of government and to further the plans and ideologies of groups in this country to influence legislation being considered by the Congress * * *"

The issues raised by Representative Harness with regard to the New Zealand study are of two kinds—one general and one specific. As to the first, Representative Harness first equates compulsory health insurance and "socialized medicine"; he then uses the phrase "socialized medicine" as though by definition it meant "foreign" (i. e., bad) and "un-American." His argument rests in large measure on the implied assumption that any study of compulsory health insurance ("socialized medicine") must of its very nature be propagandistic, nonobjective, and reprehensible.

With regard to the specific issues, there is (*a*) the question of fact as to whether or not the main emphasis of the study was to be on health insurance. In his letter of July 11 to Representative Harness, Mr. Miller said:

"You had been correctly informed that we had planned to send a member of our staff, Mr. Jacob Fisher, to New Zealand. However, he was not being sent merely or even primarily 'to study compulsory health insurance in that country' as was stated in your speech but to study the whole social-security system. Mr. Fisher's inquiries on health benefits were to be only a fraction of a broad social security study which was planned to include cash benefit provisions for old age, invalidity, unemployment, sickness, widows, orphans, minors, etc."

In his letter of reply, Representative Harness refers to the list, given in a memorandum submitted by Mr. Falk, of subjects to be studied, most of which relate to compulsory health insurance. The reference would appear to be to a memorandum dated March 21, from Mr. Falk to Mr. Mitchell. The list of aspects warranting field study includes as many or more questions relating to cash benefits as to health benefits (depending on what one counts as a separate question). Representative Harness fails to mention the later memorandum (June 10) which sets forth the developed plans for the study. The tentative outline of information to be obtained which accompanies this memorandum includes 14 questions (1½ pages) relating to the health benefits, and 34 questions (4½ pages) relating to the other parts of the New Zealand program.

(*b*) In his letter of July 11 Mr. Miller said:

"The New Zealand Social Security System is recognized among experts as being of great significance on account of its unified nature, comprehensive scope, and other special characteristics * * *. It has attracted world-wide attention, and is widely regarded as something in the nature of a laboratory experiment for testing many important and controversial proposals in the field of social security. It has been criticized by some insurance and medical writers as a bad and overambitious program that cannot succeed; and at the same time it has been held out, in a report from the Brookings Institution of Washington, as something of a model for a new type of social security program for the United States. Obviously, it cannot be all that is claimed or charged."

In his reply, Representative Harness quotes from the book by Lewis Meriam, Relief and Social Security, published by the Brookings Institution, a single paragraph reporting official criticisms of one aspect (fee-for-service) of the New Zealand health benefits plan. The Congressman concludes that "the language above quoted * * * would not justify the New Zealand plan as being a model which might be adopted by the United States Government." Mr. Miller did not in his letter claim that the New Zealand program is a model for the United States, but rather that the Meriam report so presented it. A reading of the entire Meriam book, and especially the 37 pages devoted directly to a description of the New Zealand system shows that the author has great interest in and admiration for the cash-benefit system, more particularly its income-test provisions.

(*c*) Two questions of fact were raised with regard to Mr. Fisher's article, the New Zealand Social Security Program, which was published in the September 1945 issue of the Social Security Bulletin. In his speech on the floor of the House, Representative Harness (1) characterized the article as a "report on socialized medicine" and (2) stated that it "has been described by several reputable authorities as extremely biased and dishonest."

In his letter of July 11, Mr. Miller said with regard to (1), "Mr. Fisher's article did not deal with socialized medicine. It described the New Zealand system of cash and health benefits." With regard to (2), "* * * no comments such as those you referred to have come to our attention. I trust that the sources of this criticism may be made known to us in order that we may learn the basis for the charges."

Representative Harness, in his reply of July 24, made no further reference to this second charge. With regard to the first point, he said "The coverage given medical care in Mr. Fisher's article * * * most certainly presents a picture of 'socialized medicine,'" and he listed the paragraph headings of the second section of the article, dealing with health benefits. The Congressman neglected to mention the first section dealing with cash benefits, or the third section on financing the social security program, and failed to point out that as compared with the nine columns covered by the health benefits section, the remainder of the article covered 18 columns. While it is true, as the Congressman states, that "Four or the five paragraphs in the introduction deal with New Zealand's health benefits program," it is equally true that four of the five deal with the cash benefits program (i. e., one paragraph discusses the cash benefits only, one the health benefits only and the other three discuss the program as a whole).

So trivial a misrepresentation would not be worth mentioning, were it not for the way in which it is used to cast doubt on the fairness and objectivity of the research staff, research methods ,and research reports of the Bureau of Research and Statistics.

2. *The legal authority of the Federal Security Agency to engage in studies of health insurance or to undertake studies in other countries*

In his speech before the House, Representative Harness said:

"These international junkets are an item of considerable expense. Such activities have never been authorized, directly or indirectly, in the appropriation bills."

Mr. Miller replied, in his letter of July 11, as follows:

"Your speech referred to this trip to New Zealand as a type of activity 'never authorized by Congress' and 'never * * * authorized directly or indirectly in the appropriation bills.' While you reiterated this view during our discussion in your office, I presume that any confusion which may have existed on that subject has now been cleared up by your committee counsel who has assured us that he has no question as to our authority to engage in this activity or to incur financial obligations in connection with it. His opinion in this respect conforms to that of the legal staff of this Agency.

"The Social Security Act (sec. 702) imposes a positive 'duty' upon this Agency for engaging in activities such as the one regarding which you have raised question. This duty to make studies and recommendations has always included studies of foreign as well as domestic practices and experiences . * * * I have not the slightest doubt that congressional committees would regard us as having done less than our duty under the law if they found at hearings or on other occasions that we had not taken all reasonable steps to be informed on foreign experience."

Representative Harness' letter of July 24 reiterates the charge of lack of legal authority and expands the definition of unauthorized activities to include not only (*a*) studies requiring foreign travel, but also (*b*) studies of health insurance.

With regard to (*a*) studies requiring foreign travel, Representative Harness says:

"You have stated that counsel for my committee has assured the FSA that he has no question as to its authority to engage in this activity or to incur financial obligations in connection with it. Mr. Bow, who is counsel for the committee, has advised me that no such advice has been given by him to the Federal Security Agency, or any other department or agency of Government. Mr. Bow recalls that, at the time of the hearings on the health workshop, inquiry was made of him regarding any prohibition by statute, relating to foreign travel. Mr. Bow's reply was that, at that time, he could cite no prohibiting statutes nor statutes authorizing the travel; and he suggested that, as counsel for the committee, further study would be made of the subject. The subcommittee counsel study does not conform with that of the legal staff of your agency."

This statement is directly at variance with the account of Miss Gladys Harrison, the member of the staff of the General Counsel of the Federal Security Agency who talked with Mr. Bow. Miss Harrison completely affirms the correctness of the statement in Mr. Miller's letter of July 11 and indicates that when she talked with him, Mr. Bow as well as we had no doubt as to the legal authority of the Social Security Administration to send an employee abroad to make a study of the social security system of another country. Congress has, in the past, specifically authorized the expenditure of funds for foreign travel, and such authorization has continued without question since 1940, in spite of changes in the language of appropriation bills.

In his letter of July 22, Representative Harness refers to a memorandum dated April 1, 1947, from Maurine Mulliner to the Bureau directors as evidence that "the attitude of Congress on foreign studies was known to the Federal Security Agency." The memorandum in question suggests that in view of congressional attitudes with respect to the budget, there is doubt as to the wisdom of proceeding with a proposed project to study social security in a number of other countries. The reference in the memorandum is to the general attitude of Congress in the spring of 1947 toward the amount of the executive budget and has no bearing whatsoever on the question of the legal authority of the Federal Security Agency to engage in studies requiring travel abroad.

Representative Harness' July 24 letter goes far beyond the statement in his original speech when it challenges the legal authority of the Federal Security Agency to study health insurance. In making this charge, Representative Harness uses arguments recently advanced by Mrs. Marjorie Shearon. The argument relies on the fact that the original social-security bills included "health insurance" as one of the specifically designated subjects which the Board should study, whereas section 702 as passed did not include this phrase. An examination of the reports of the House and Senate committees on the social security bill reveals no evidence that this change in wording was intended to effect any substantive change or to do more than eliminate a particular phrase which had given rise to misunderstandings and to controversies as to its meaning. It was understood at the time among the Government people that the general subject was still covered by the final phrase in secton 702 "and related subjects."

Since the passage of the Social Security Act, the Congress has repeatedly and knowingly appropriated funds for the study of health insurance by the Bureau of Research and Statistics.

3. The Alleged Communist-Front Associations of Mr. Jacob Fisher

The Agency has attempted to obtain an immediate and complete investigation of the charges against Mr. Fisher. The Administrator referred the matter to the Agency loyalty board which asked the Civil Service Commission to undertake an investigation. The Civil Service Commission advised us to request the FBI to make an investigation. This request, signed by the Administrator, went to the FBI on August 15. We are not, of course, attempting in any way to duplicate that investigation or to anticipate its results. There are, however, a few facts with regard to the matter which can be summarized at this time.

In his speech of June 16, Representative Harness said:

"We find that this same Jacob Fisher has been documented by the House Committee on Un-American Activities for almost uninterrupted association since 1939 with various Communist-front and fellow-traveler organizations. At various times Jacob Fisher has been identified with seven different groups or organizations avowedly sponsoring the Moscow party line in the United States."

As soon as possible after the Administration learned of Representative Harness' speech, an immediate preliminary investigation was made of the charges against Mr. Fisher. Early on June 17, the day following Representative Harness' speech, Mr. Wagy, personnel officer, Social Security Administration, went to the office of the Committee on Un-American Activities to check on the committee reports. He found references to Mr. Fisher's membership in seven separately listed organizations (four of which were branches of or associated with the North American Committee to Aid Spanish Democracy) and to his association with the periodical, Social Work Today. Mr. Wagy also went that afternoon to the offices of the Harness committee and conferred with Mr. Bow, the counsel of the committee, in an attempt to learn the basis for the charges against Mr. Fisher. Mr. Bow referred particularly to the magazine Social Work Today, a journal for "rank and file" social workers which was started in the mid-thirties and ceased publication about 1942. Copies of the magazine were subsequently obtained and examined by the persons in the Agency concerned with the case, including Mr. Watson Miller himself.

When he learned of Representative Harness' speech, Mr. Fisher made an attempt to check on the statement that his name was listed in the reports of the House Committee on Un-American Activities. He found only one reference to his name in the 1942 index to the committee reports, a reference to the Social Workers' Committee to Aid Spanish Democracy, and so reported in a memorandum to Mr. Falk (dated June 17, 1947). On June 18, Mr. Fisher gave Mr. Falk the names of the organizations in which he then held membership, and those in which, to the best of his recollection, he held membership at any time between 1939 and 1947, the period referred to in Mr. Harness' statement. The list included some, but not all the organizations found by Mr. Wagy in the Dies committee reports, a discrepancy, it appears, due to the difference in the time periods involved. His connection with Social Work Today was discussed by Mr. Fisher with Mr. Falk.

On the basis of a review of Mr. Fisher's personnel file and of the information obtained by Mr. Wagy from the House Un-American Activities Committee reports and from Mr. Bow, supplemented by Mr. Fisher's reports to Mr. Falk, the Agency reached the conclusion stated in Mr. Miller's letter of July 11:

"* * * the data obtained thus far from your committee counsel, from the House Committee on Un-American Activities, and from Mr. Fisher himself impress me as not justifying so serious a reflection upon the reputation of a person whose conduct and service, so far as we have been able to observe, have been beyond reproach."

In his reply of July 24, Representative Harness challenged this statement and said:

"* * * it is again obvious that those upon whom you rely have withheld facts from you, or have distorted facts to which you were entitled. I have seen Jacob Fisher's report to Mr. Isadore Falk, dated June 17, 1947, relative to his investigation of the published volumes of the Un-American Activities Committee.

If the accuracy of his investigation in this matter is any criterion upon which his ability might be tested, I am sure that further study or investigation by the individual should not be considered or contemplated.

"Mr. Fisher failed to mention the magazine, Social Work Today * * *"

Two points should be noted with respect to this statement: (1) The Federal Security Agency did not, as Representative Harness implies, rely upon Mr. Fisher's memorandum of June 17 in reaching the conclusion expressed in Mr. Miller's letter. (2) Mr. Fisher's memorandum of that date correctly reported the one reference to his name in the indexes to the committee reports which are published and available to the public. The additional references found by Mr. Wagy were listed in a volume which so far as we know has never been released to the public, and which can be consulted in the offices of the House Committee on Un-American Activities only by permission. As the chief personnel officer of the administration, Mr. Wagy was given access to the volume. When Mr. Fisher subsequently requested permission to see the volume, his request was refused.

The staff report included with Mr. Harness' letter cites in some detail the various activities and organizations with which Mr. Fisher has been associated in the past. In view of the Administrator's request to the FBI for a complete investigation of the charges against Mr. Fisher, we are not commenting at this time on the staff report.

Senator Donnell. May I ask Mr. Falk whether or not this statement in the Harness report I have referred to, page 7, is correct? [Reading:]

> Under date of May 14, 1947, Mr. Isadore Falk, Director of the Bureau of Research and Statistics, sent a memorandum to the Acting Commissioner for Social Security, urging that one Jacob Fisher, a member of Mr. Falk's staff, be sent to New Zealand at Government expense, to study compulsory health-insurance programs and activities in that nation.

Is that a correct statement, Mr. Falk?

Mr. Falk. It is correct, but like almost everything else in this document it is only partly correct.

Senator Donnell. Would you mind telling us the extent to which it is correct and the extent to which it is incorrect?

Mr. Falk. Yes, sir. May I tell you the whole story in brief form?

Senator Donnell. Yes, certainly. Go right ahead.

Mr. Falk. It seems to be of interest to the committee.

Senator Donnell. Yes.

Mr. Falk. Because of the statement in the Harness report, I think it has been misunderstood. Perhaps it has been very badly misunderstood.

Senator Donnell. Pardon me, Mr. Falk. Before you proceed, I have no objection to your proceeding in full. I just want to know what it is you are addressing yourself to. Are you addressing yourself to this quotation I just read to you?

Mr. Falk. Yes, sir. I thought I would give you the picture, as briefly as might be, of how it came about and why, as this quotation says, Mr. Fisher was recommended by me to be sent to New Zealand to make a study.

Senator Donnell. All right, go right ahead.

Mr. Falk. The first point, the idea of sending staff members to other countries to study social security at this time originated in the office of the Commissioner.

At a meeting of bureau directors called on March 13, 1947, by Mr. Mitchell, who was then the Acting Commissioner, and which I attended, he informed us that the Commission thought that the administration should pick up again——

Senator Smith. May I ask, Commissioner of what?

Mr. FALK. The Commissioner for Social Security. Mr. Altmeyer is the Commissioner for Social Security.

Senator SMITH. I did want you to identify him so that we would know whom you were talking about.

Mr. FALK. The Commissioner himself thought we should, after the war was over, pick up again and follow on with our studies of social-security experiences and situations in other countries.

Mr. Mitchell, who was then the Acting Commissioner since the Commissioner was abroad on service out of the country, informed us that there were some travel funds available for the current fiscal year, and he asked the various bureau directors their opinions and ideas on aspects of social security which might advantageously be studied in other countries to bring our information up to date.

He said that the funds that were available might permit one staff member from each bureau to visit foreign countries worthy of study, and he asked us to think about it. It originated with Mr. Altmeyer; and we were asked to give Mr. Mitchell a memorandum indicating our ideas on which countries might profitably be visited, and which aspects of their social security program it would be worth while for a bureau to study.

It was agreed at that meeting that the Bureau of Research and Statistics would make available to other bureaus information in its files concerning foreign social security programs and would also assist other bureaus in developing their plans.

I might say in that connection that the Bureau of Research and Statistics had for many years, perhaps almost from its inception, been the primary source of information or the focal point of information on foreign social security systems for the Social Security Board, for the Agency after that was created, and for many departments of Government, as well as for nongovernmental organizations, business firms, civic organizations, professional organizations, and citizens who called upon us for information concerning social security in other countries.

Well, on March 21, 1947, I sent to Mr. Mitchell a memorandum suggesting it would be worth while for a staff member of our Bureau, the Bureau of Research and Statistics, to make a trip to New Zealand to study their social security program. The reasons for this suggestion are given in that memorandum, of which I have a copy here. Copies of this memorandum were sent to the other bureaus.

In the interim we had also done some review of available information for other bureaus of the Social Security Administration—the Bureaus of Employment Security and Old Age and Survivors Insurance. I won't pause at the moment, though perhaps if you are interested I would be glad to return to it later, to tell you about the reasons I gave at that time for advising an inquiry into the New Zealand social security system; but I thought I would give you a brief chronology of what preceded and what occurred in connection with this sentence which has been quoted from the Harness report.

Mr. Mitchell scheduled another meeting of the Bureau directors to discuss the proposals that the bureaus had suggested. He later canceled this meeting and postponed further discussion for the time being.

Then the Commissioner's office again listed the proposed subject, foreign social security studies, on its agenda for discussion at the Commissioner's staff meeting for May 9, 1947. It is my recollection that Mr. Mitchell, the Acting Commissioner, said he had been in touch with the Commissioner, Mr. Altmeyer, and that the latter still thought the program of foreign social security studies should be pursued further.

Mr. Mitchell asked that each bureau interested in the possibility of sending staff members to other countries submit a justification indicating the purpose of the project, timeliness, and so forth.

I indicated at the meeting why I thought that the social security programs of New Zealand and possibly Australia would be worthy of study at this time, as against the programs in various European countries. Consequently, I sent Mr. Mitchell the memorandum of May 14, 1947. That is the date of the memorandum to which the Harness paragraph refers, giving the reasons justifying the visit to New Zealand and its timeliness and our recommendation that Mr. Jacob Fisher be given the assignment and the reasons therefor.

Subsequently Mr. Mitchell sent me a memorandum, dated May 21, 1947, asking that since the New Zealand trip would concern the program bureaus of the Social Security Administration, we should ask them for their suggestions on those aspects of the New Zealand social security system on which they would like information and for their comments on the usefulness of the trip, and for Mr. Jacob Fisher to make the trip.

After Mrs. Merriam had talked to the Bureau directors concerning the trip and Mr. Fisher's assignment, I called Mr. Mitchell and told him the other bureaus thought the trip would be useful to them.

Subsequently, I won't go into all the details, I received word from the Commissioner's office to proceed with the plans for the New Zealand trip.

Now I am not going on into the details of what happened afterward when the Harness attack came, but I would like to refer to at least one other point which bears on this quotation.

Senator SMITH. Let me ask you, Mr. Falk, did Mr. Fisher take the trip?

Mr. FALK. No, sir; it was postponed.

Senator DONNELL. Why was it postponed?

Mr. FALK. May I go on, then? Very shortly before he was scheduled to go——

Senator DONNELL. Where was he when he was stopped from going?

Mr. FALK. He was in his office in Washington, D. C., and in his residence. He was on duty here.

Senator DONNELL. He was about to go at that time, was he not?

Mr. FALK. He was scheduled to go on June 20; the tentative date set for his departure was June 20, 1947.

Senator DONNELL. What happened?

Mr. FALK. Well, late in the day on June 16, 1947, we learned of Mr. Harness' attack in the form of a speech on the floor of the House concerning this trip and his attack and his criticisms and his allegations against Mr. Fisher.

It was directly after that, beginning with the next day, as I said earlier, that the Bureau and the Administration and the Agency undertook a preliminary investigation of these charges against Mr. Fisher. On the basis of the preliminary investigation, the Federal Security Administrator directed that Mr. Fisher not proceed with the trip; that the trip be postponed until the investigation which had been instituted with respect to these charges against Mr. Fisher was completed, and I believe in one of the letters to which I referred which Mr. Miller, the Federal Security Administrator, addressed to Mr. Harness, he said something to this effect, that while Mr. Harness' charges with respect to the purposes of the trip did not persuade the Agency that it had committed any error of judgment in planning the trip, in view of the questions that had been raised about the fitness of the individual, the trip was postponed until that question could be resolved.

Senator SMITH. Who was going to pay for the trip, Mr. Falk?

Mr. FALK. The Federal Security Agency's travel funds. That was an official undertaking, and Mr. Fisher was to travel as an officer of the United States Government, proceeding to make an inquiry for the Agency.

Senator SMITH. Wasn't that about the time these hearings were going on in regard to these matters, and we were discussing New Zealand among other things?

Mr. FALK. Well, it was about the time these hearings were going on. I don't remember that there was any particular discussion of New Zealand.

Senator SMITH. We discussed right straight through all these plans of work in New Zealand. I was thinking if there was going to be an investigation, it ought to have been in connection with what we are trying to find out here. We would send people who would look at all sides of it and not somebody who was apparently so much filled up with enthusiasm for this plan that he would bring us back a report that might be all one way.

We tried in our other investigations to make these two-way streets so we would get all the information and not have reports that seemed to be pointed to a conclusion.

Mr. FALK. Quite so. That is on a point which I would like to make one further remark about. The Harness statement said, "be sent to New Zealand at Government expense to study compulsory health insurance and activities of that nature."

If he were being sent for that, we would not have selected Mr. Fisher, and that would not have been the arrangement for the trip. The point of the matter—and I will be glad to give you details of that or furnish memoranda for the record—is that Mr. Fisher was going to New Zealand to study the New Zealand social-security program in its totality, as a whole, with primary interests in such matters as the income test and similar arrangements in the New Zealand plan, which make it a comprehensive and more or less inclusive social-security system for old-age retirement, disability, and widows' provisions and orphans' and children's provisions and family allowances, et cetera, and health benefits.

Now, our interest in making a study of the New Zealand program was not primarily or even, I would say, in the main sense the health program, but this comprehensive social-security program which covered the whole population and used many novel arrangements not to be found in any other substantial social-security system in the world. Mr. Fisher was selected to make that trip because he had already made a fairly extensive study of the New Zealand system—as extensive as he could from documents and other sources of information available here, and Mr. Fisher had been selected for that originally primarily because our interest at that time in the New Zealand program was in the way in which it undertook to work out new solutions as to social insurance and public assistance.

You see, Mr. Fisher had been an expert, a technical expert, in the public-assistance field, and his original studies of the New Zealand system didn't arise because of any particular interest in the health aspects of the matter but because of the rather unique way in which they handled what we in America call public-assistance or old-age insurance.

Now, in planning his study of the New Zealand system he, of course, could not and did not overlook the health benefits which they have under their very comprehensive program, and in the earlier studies which he had made, the two publications of his, his studies and his reports had included the health benefits among other matters, the cash benefits.

Senator PEPPER. May I interrupt, Doctor. Do you know of any suggestion that the making of such a trip or the conducting of such an inquiry by the Bureau was outside the scope of their law or appropriation?

Mr. FALK. The only question of which I have knowledge at this time, Senator, is Mr. Harness' challenge of it.

Senator PEPPER. His challenge on the basis—the authority for such a trip not existing?

Mr. FALK. No, sir. He challenged the authority as well. As a matter of fact, there has been some confusion.

Senator PEPPER. Isn't it a customary practice for representatives of the United States Government to go to various places in this country and out of this country to get information to carry on the work of the Bureau or the Department?

Mr. FALK. Why of course it is the regular practice and I should think that we would be guilty of neglect, or we would be subject to criticism, serious criticism, if we were not keeping ourselves informed of social-security developments and operations and experiences of other countries. I doubt very much that any member of the Appropriations Committee would have any question that when they provide travel funds and do not put any specific injunction against such practice, but that it would be regarded as a normal and proper and regular occurrence for us to make inquiries in foreign countries when such inquiries are indicated, as well as in this country.

Senator PEPPER. The Bureau of Public Health, which is in the Federal Security Agency also, I assume, sends out people to make studies in this country and outside the country about health matters, does it not?

Mr. FALK. Oh, yes, sir; certainly.

Senator DONNELL. They have stations all over the world, have they not?

Mr. FALK. They have some officers who are regularly stationed abroad for quarantine purposes, but from time to time they send officers on special missions. As a matter of fact at the time this New Zealand episode arose, and I think it is significant for some reason which is a little difficult for me to decipher, at least two other officers of the Social Security Administration went on foreign inquiries as part of this same program of which this was a piece.

Nobody has criticized or questioned or challenged the fact that an officer of our Bureau of Public Assistance, the Director of that Bureau herself, made a trip abroad to study certain aspects of public assistance; and an officer of our Children's Bureau under Miss Lenroot was the third person in this program who made a foreign trip and was not criticized.

Senator PEPPER. Do other governments send people from time to time to this country to study aspects of our lives?

Mr. FALK. We have a great many coming to us throughout the year, and on almost any day of the year there are anywhere from a few to many of them who are here studying our social security operations, finding out about them, inquiring; I suspect that as of today, this hour there may be a half dozen, a dozen or more of them making such studies.

Senator SMITH. Doctor, I am not questioning that. I think you are entirely right about that. What I was trying to get at is whether we have a controversial question in regard to whether New Zealand is or is not successful, it seems a strange coincidence as we come for our hearings here a man was sent from your Bureau without consultation or anything else.

Mr. FALK. Senator, there was no connection, so far as we were concerned.

Senator SMITH. I am not charging that. That is all right.

Mr. FALK. The point I make is that the health aspects of the matter were one portion of it because that is part of the very comprehensive New Zealand program, and as I said earlier, we had not selected a health expert. We selected an expert in other aspects of the social security subject, asked him incidentally as part of his study to bring in the health picture, which he had already brought into his own studies of the New Zealand system.

Senator DONNELL. You say Mr. Fisher was not a health expert?

Mr. FALK. Not what we would regard as an expert in terms of this subject being pursued by this committee. He is quite well informed, as would be a person who has been working in the social-security field, but not primarily trained nor specially charged with work in the health field.

As I started to say to the chairman, if we were sending someone to New Zealand or to any other country to make an inquiry of the health subjects that are being explored by this committee, I think I am quite justified in saying we should not have chosen Mr. Fisher for an assignment in that field, and the inquiry might have been made with quite a different lay-out of program or even of the countries to which he was going.

Senator SMITH. I am just wondering if Mr. Fisher had gone and come back with a very glowing report of the New Zealand set-up, it would have been perfectly natural for you to see that that got into this record.

Mr. FALK. Yes, sir. I think, however, it is extremely improbable in view of the information already available to us from documents and other sources that there was any danger whatever that Mr. Fisher would have come back with a glowing or uncritical account of the New Zealand experience.

I think if he had gone forward with the trip he would have brought back to us a fair and reasonable account of the successes and the failures that they appear to be meeting in New Zealand, and would have documented that information so that others in turn would have been able to have known the evidence on which his statements rest.

Senator Donnell. Mr. Falk, has Mr. Fisher at any time been charged with responsibility for the study of health insurance in any of these bills that have been before Congress from time to time, these Wagner-Murray bills?

Mr. Falk. Not as such, though as any member of the staff might have been, he might have been given an assignment to look at some particular aspect of a bill that went into a field in which he was well informed.

Senator Donnell. Have you finished concerning Mr. Fisher?

Mr. Falk. Yes, sir.

Senator Donnell. All right. Now, Mr. Cohen——

Mr. Falk. May I add one other point which I think bears on the remarks the chairman made?

I said earlier the New Zealand scheme is a very unusual scheme, perhaps the most unique in the world in comprehensive social-security program, and our special reason for selecting New Zealand, among other reasons—there were many reasons—was that while some aspects of their health program were being severely criticized or being reviewed critically in this country, the New Zealand scheme as a whole in its general pattern was, I think I am justified in saying, being rather vigorously advocated as one for us to consider in the United States as a substitute for the social-security system we have.

You may know—perhaps you do, Mr. Chairman—that the book by Lewis Meriam on Relief and Social Security, which makes rather extensive reports on our security program and problems we meet, uses for many of its major conclusions and recommendations the pattern of the New Zealand program. I cite that as an illustration of the kind of interest which the New Zealand social security program has received from sober and responsible students of the subject in this country.

Senator Donnell. Now may I proceed with Mr. Cohen? Have you finished, Mr. Falk, on the Fisher matter?

Senator Pepper. Mr. Chairman, are you going to interrogate Mr. Cohen about the subject of the Harness report?

Senator Donnell. Well, I intend to interrogate him in regard to this letter which he wrote to Mr. Falk. There may be some further ramifications that I do not anticipate.

Senator Pepper. All I wanted to request was about 4 or 5 minutes before the committee adjourns. I just want to read an editorial in comment on the Harness report by the American Journal of Public Health.

Senator Donnell. Mr. Chairman, might I suggest that Senator Pepper be permitted to do that at this time? It is almost 12:30.

Senator Smith. I might say to the members of the committee and the witnesses, we are planning to recess at 12:30, until 2 o'clock, and if Senator Donnell is willing to yield to let Senator Pepper introduce the editorial at this time, he may proceed.

Senator Pepper. I do this because the Harness report has received considerable publicity and I would like those who have heard some excerpts of it just to have it for whatever it may be worth.

This editorial is reprinted from the American Journal of Public Health, volume 37, No. 12, December 1947, published by the American Public Health Association, 1790 Broadway, New York, N. Y. [Reading:]

On July 2 last the subcommittee of the Committee on Expenditures in the Executive Departments Authorized To Investigate Publicity and Propaganda of Federal Officials in Formation and Operation of Health Workshops made a report to the Committee of the Whole House. This report has somewhat serious implications—although these implications may be somewhat different from those which the subcommittee itself had in mind. The fact that the Journal of the American Medical Association has editorially summarized the report in question warrants a study of its content.

There are essentially two sets of facts brought out in this report and used by its framers as the basis for an attack on—

1. The United States Public Health Service.
2. The Children's Bureau.
3. The Office of Education.
4. The United States Employment Service.
5. The Department of Agriculture.
6. The Bureau of Research and Statistics of the Social Security Board.

The first of these facts was that Surgeon General Parran on December 10, 1945, transmitted to all officers of the Public Health Service a copy of House Document 380 which was President Truman's message to Congress on a national health program. He said in comment:

"Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service."

Since June of that year (1945) all officers of the Service had been, by Executive Order 9575, covered into the armed forces with full military rights and obligations. Even under civilian conditions, however, such a warning as that issued in December 1945 would have been entirely proper. The United States Public Health Service is a branch of the Federal Government, and it would be most unfortunate for any subordinate officer of that Service to "make statements likely to be interpreted as representing the official views of the Public Health Service" if those views were in opposition to those of the head of the Government, whether acting as Commander in Chief of the Army or in his normal civil capacity.

The official views of the Service on any technical matter must be formulated by the Surgeon General himself. If his views differ from those of his official political superiors, he can only resign. We infer from certain earlier writings of Dr. Parran that he did not feel the President's speech called for any such action.

He might have taken much more vigorous steps. It would have been quite within his rights to point out that the need for some form of compulsory prepayment of medical costs is as important for the health of the American people as is the need for vaccination against smallpox. He did not follow any such course; he merely acted to protect the Service against the danger of possible criticism, by members of the Federal family, of the policies advocated by the chief of State.

The second mare's nest uncovered by the subcommittee is the fact that between November 1945 and November 1946, a series of 26 workshops were held in various parts of the country, under the auspices of the Service, for the discussion of problems relating to medical care.

We deplore the word "workshop," but it has become a routine part of educational lingo. In any case, groups of citizens and experts in various areas of the field were convened and Federal employees participated in the discussion of methods by which the important issues concerned could be brought before interested groups, so as to stimulate thought.

The subcommittee concludes that these discussions were planned "subtly to generate public sentiment in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine." By the by, the subcommittee is very fond of this phrase, "what certain witnesses and authors of propaganda refer to as socialized medicine", repeating it half a dozen times. It puzzles us a bit. In the language of bodies like this subcommittee, "propaganda" usually means the other fellow's argument; and no person well informed enough to discuss health insurance intelligently ever uses this phrase "socialized medicine" which has no intellectual content and is used only to stimulate the endocrines.

There seems no valid reason why technical experts in the Government service should not meet with groups of interested persons to discuss pressing public-health problems. It is an important part of their duty to do so. No convincing evidence is adduced of the subtle generation of public sentiment; and whether we like the word or not, the workshop is about as good a medium for democratic discussion as has yet been devised.

All this is pretty small potatoes for the activity of a group of representatives of the American people, convened in a Congress which faces the gravest world problems which have ever confronted the Nation.

Even more serious, however, is the last paragraph of the subcommittee report: "Suffice it at this time for your committee to report its firm conclusion, on the basic evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances known Communists and fellow travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard."

As to the Moscow party line, the members of the subcommittee will perhaps be interested to learn that the United States of America and Union of Soviet Socalist Republics are the only two leading countries of the world which do not have some system of compulsory health insurance. They do not have it in the Soviet Union because they have a system of state medicine (which is radically different). For the United States to adopt such a plan would be to follow London, Paris, and the capitals of Holland and Sweden and Norway and Denmark—in direct opposition to Moscow.

As to the business of fellow travelers, the actual evidence which the subcommittee has been able to collect is as follows. If it had any better evidence it would, no doubt have welcomed it. The facts submitted were as follows:

(*a*) An obscure member of the staff of the Social Security Board "has been documented by the House Committee on Un-American Activities for almost uninterrupted association, since 1939, with various Communist and fellow traveler organizations in the United States" according to the subcommittee. How far such "documentation" may be justified we have no means of knowing. There is no evidence that he was ever condemned by any court; and it is easy to accuse.

(*b*) It was once suggested in an office memorandum of the Security Board that this individual might be sent to New Zealand to study its health insurance program.

(*c*) The Social Security Board "maintains close contact with movements for compulsory health insurance in other countries."

(*d*) Another employee of the Social Security Board once assisted Senator Wagner in drawing up a health insurance bill.

(*e*) Therefore, the Social Security Board is a Communist-front organization.

(*f*) Much of the literature used in the workshops was prepared by the Social Security Board. (This could scarcely help being the case since the studies made by this Board furnish the most authoritative statistical data we have, with respect to medical economics.) Unfortunately for the clarity of the subcommittee's conclusions, neither the suspected Communist nor the head of the research and statistics participated in the workshops.

But (*g*) since the workshops used literature prepared by the Soocal Security Board (which had a humble employee accused of being a fellow traveler) the United States Public Health Service which sponsors the workshops must be tainted.

And finally (*h*) since employees of the Children's Bureau, the Office of Education, the United States Employment Service, and the Department of Agriculture sent representatives to the workshops they are probably fellow travelers too.

On this house that jack built (or shall we say that Jerry built?) the subcommittee bases its conclusion that "known Communists and fellow travelers with the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line." Six bureaus of the Federal Government are pilloried because one employee of one of them has been charged with being a fellow traveler, and the Attorney General has been officially asked to prosecute offending employees for taking part in workshops mentioned.

The true motivation of the subcommittee is, probably, a quite different one. It appears to assume throughout that advocacy of health insurance is ipso facto an evidence of communism. If this be the case, President Truman should be impeached for his message of 1945; and since the Seventy-ninth Congress did not condemn his address as emanating from Moscow, all its Members must be considered as fellow travelers. Indeed the Eightieth Congress might deserve the same designation, since its Members sit in the same chambers with many who supported the Wagner-Murray-Dingell bill and who must be ipso facto, Communists.

The final paragraph of the report of the subcommittee is the text for a shocking circular sent out to all physicians and dentists by the National Physicians Committee. It makes those who respect and love the medical profession somewhat heartsick to see the names of 13 physicians (most of them of outstanding position in the American Medical Association) at the head of this broadside.

We have no sympathy with communism as a political movement. We believe that it is necessary to protect the United States against the influence of such citizens of our country as may hold secret allegiance to any foreign power. The spirit of totalitarianism is, however, even more dangerous than its puny human emissaries.

If we adopt the methods of totalitarian ideology we are surrendering to the very worst element which is common to both communism and fascism. That is what is happening when we demand absolute conformity with the social program of one group which happens for the moment to be in power; stifle discussion, call everyone who differs a Communist and everyone who has ever been associated with any organization in which there was ever a Communist member, a fellow traveler. Such an attitude abandons reason for ideology, and philosophy for perverted semantics. It overwhelms empirical evidence in a flood of catchwords. It enthrones emotion above reason, by discovering un-American art and un-American music and un-American science.

The writer of this editorial has behind him 10 generations of New England stock. He learned that the American tradition meant freedom of thought and of speech (up to the limit of legally prosecutable action); that it meant openmindedness and readiness to try experiments; that it meant initiative in the working out of the problems of society; that it meant experimentation and progress.

The other road—that of rigid conformity with the theory of a temporarily powerful group—of defining not only what a man must do but what he must think and feel—and with whom he may be acquainted—is the road to what is truly un-American. This was the technique of the Hitler regime in Germany and is the technique of the Communist leaders in Russia. Pray God, it may never become the prevailing mood of America.

Senator SMITH. The committee will stand recessed until 2 o'clock.

(Whereupon at 12:35 p. m. the committee recessed until 2 p. m. of the same day.)

AFTER RECESS

(The subcommittee met at 2 p. m., pursuant to recess.)

Senator SMITH. The meeting will please come to order.

The committee will continue with Mr. Cohen as our witness.

Senator Donnell?

Senator DONNELL. Mr. Cohen, there was read this morning into the record a photostatic copy of a certain letter of February 15, 1946, from yourself to Mr. Falk, which included the New Zealand Medical Care Plan. At the outset of that letter, you said, "I had an appointment yesterday with Mr. W. B. Sutch."

Where did you meet Mr. Sutch for the first time?

Mr. COHEN. I met Mr. Sutch in his office at UNRRA.

Senator DONNELL. How long before February 15, 1946, did you meet him?

Mr. COHEN. I met him on February 14. My memorandum refers to an "appointment yesterday with Mr. W. B. Sutch," and that was the first and last time I ever laid eyes on him.

Senator DONNELL. Well, how did you happen to lay eyes on him on February 14?

Mr. COHEN. A friend of mine called me up.

Senator DONNELL. Who was that friend?

Mr. COHEN. Miss Hoey, the director of the Bureau of Public Assistance, called me one day and said that there was a gentleman here from New Zealand, who knew a great deal about the New Zealand Medical Care Plan, and she thought I would be interested in meeting him and talking over the New Zealand program and his comments and observations. When Miss Hoey called me, I said I would be very delighted to talk with Dr. Sutch, to get his opinions and observations. I asked her if she would be kind enough, as she suggested, to make an appointment with Dr. Sutch at his convenience, and I got a message back that he would be glad to see me at such and such a time and at such and such a place. Then I went over to see him with Mr. Fisher.

I may say at the time I went over to see him, I had no motive or no idea in my mind whatsoever other than to see him and to get his opinions and reactions for what they were worth. I had no idea in my mind of asking him or requesting him for any statement or any written document or for him to prepare anything for any use whatsoever. It merely occurred to me during the course of his statement, in which he said that he was very indignant about the misrepresentations which were being circulated about the New Zealand plan, that Senator Murray, then the chairman of this committee, had requested Dr. Falk and had at least on two or three occasions to me personally said that he would like information concerning the charges made about the New Zealand plan.

Senator Murray. If I might interrupt, I would like to say that I received a letter from some doctor in New Zealand in which he told me that he had been reading the American magazines and the American Journal of Medicine and that he had observed in the articles that he had been reading glaring misrepresentations with regard to the system that they had in that country. I believe I inserted that letter that I received from him in the record. I never heard of him before; didn't know he even existed. The letter came to me as a complete surprise, and I put it in the record.

That raised in my mind the idea of trying to find out what the real system was in that country and to try to find out whether any of these criticisms had any merit to them. I may have spoken to somebody over in your department about it to learn for my own information what the situation was.

Mr. Cohen. As I was saying, Senator Murray did speak several times about these charges and countercharges, and I felt quite embarrassed that we had no information in this country from a person who had been intimately connected or associated with the actual operation of the plan. I had myself read innumerable reports on the plan, the law itself, some of the regulations and some of the newspaper accounts, but it occurred to me during the course of this rather incidental conversation with Dr. Sutch, for my own edification, that since he felt this way and felt very strongly, may I say, from the conversation, that he might want to present his views to Senator Murray.

He was the one who offered to make the statement, and I then said, on my own initiative, that I thought Senator Murray would welcome any statement that he wanted to make, because he had said to me personally, of my own knowledge, at least on two or three occasions, that he would like to know more about the New Zealand plan and in particular about these charges that had been made.

Senator Donnell. Do you know how Miss Hoey had learned of the presence of Dr. Sutch in this country?

Mr. Cohen. No, sir; I don't.

Senator DONNELL. She is connected, is she not, with the Social Security organization?

Mr. COHEN. Yes, sir. She is the director of the Bureau of Public Assistance, which administers the Federal grants-in-aid to the States for the needy aged, blind and dependent children.

Senator DONNELL. And she was in that capacity at the time when she called you?

Mr. COHEN. Yes, sir.

Senator DONNELL. She was then in that official capacity?

Mr. COHEN. Yes, sir; and still is.

Senator DONNELL. So you took Mr. Fisher over with you to this conference, did you?

Mr. COHEN. Yes, sir.

Senator DONNELL. But, as you say, you did not have any idea of asking Dr. Sutch to make any statement when you went over with Mr. Fisher?

Mr. COHEN. I had intended to ask Dr. Sutch if he had any material of any written sort, articles or books. I knew somewhere that he had written something on New Zealand, and I wanted to ask him if he had anything more up-to-date that would throw light on the New Zealand plan.

Senator DONNELL. Did you know anything about his connections in New Zealand when you went over?

Mr. COHEN. None other than, I believe, what Miss Hoey told me, that he had been intimately connected or associated with the formulation of the plan and its administration. I might say that in the course of perhaps the year or two before, in showing interest in the New Zealand plan, we did have contact with Mr. Nash, who I believe at that time was the Ambassador from New Zealand to the United States.

Senator DONNELL. Mr. Walter Nash?

Mr. COHEN. Mr. Walter Nash, who talked to the entire staff to give his observations, because he had been, I believe, the Minister of Health or Minister of Social Security or perhaps both.

Senator DONNELL. Wasn't he the Minister of Finance?

Mr. COHEN. I believe he was Minister of Finance at one time when the Minister of Finance was largely responsible for piloting the bill through Parliament, and then later he became, if my memory serves me correctly, the first Minister of Social Security.

Senator DONNELL. That is, by the expression "piloting the bill," you mean piloting the New Zealand Social Security Act of 1938. Is that right?

Mr. COHEN. Yes, sir. In the parliamentary system of government which New Zealand has, I believe the minister of the special field is responsible for taking charge of the legislation as it goes through the Parliament.

Senator DONNELL. When you went over to this conference with Dr. Sutch, you already had knowledge then, had you, that Dr. Sutch had been associated very closely with Mr. Walter Nash, who, as you stated, had piloted through the New Zealand Social Security Act of 1938?

Mr. COHEN. Yes, sir.

Senator DONNELL. Why did you take Mr. Fisher with you to that conference?

Mr. Cohen. I took Mr. Fisher with me because Mr. Fisher had been doing a good deal of the studies on our staff on the New Zealand system, and the New Zealand system, Senator, as Dr. Falk indicated, is a new system in the social-security field. It is generally considered in a class by itself, as a distinct type, separate and apart from either the type that exists in other countries in the world or in the United States. It has many intricate and distinctly new and novel features in its eligibility provisions, in its financing, in its income tests and the methods of its administraton. It is exceedingly technical, and I felt that someone should come along who would have that technical knowledge.

I felt that I had a general knowledge from my reading of the 1938 New Zealand law and following some of the discussion on it, but I felt that since the charges and countercharges that had been made about the New Zealand plan in part depended upon the technical knowledge of the methods of financing and the methods of payment, I should have someone along who knew the details somewhat more specifically than I did.

Senator Donnell. Did you know when you went to the conference that Mr. Sutch was a member of the Labor Party?

Mr. Cohen. No, sir.

Senator Donnell. Did you learn that during the course of the conference?

Mr. Cohen. I don't believe I did precisely, Senator.

Senator Donnell. Did you learn that Mr. Sutch had assisted in putting forward the New Zealand Social Security Act of 1938?

Mr. Cohen. He told us in some detail in our extended conference that he had; I don't know just the correct word to use, but that he played a large part in the formulation of the bill, although I believe, sir, that he was a civil servant in the capacity in which he advised the responsible Minister of New Zealand.

Senator Donnell. You learned, however, during the conference with him that he was favorable to the New Zealand Social Security Act of 1938 and had assisted in the passage of that act? You learned that, did you not?

Mr. Cohen. I learned that very readily, Senator, because on his own motion, he immediately upon discussing these articles with which he was familiar felt very indignant about them and felt that they misrepresented what the actual law and its operation was in New Zealand, and I presume, as a New Zealander, he felt that it gave an incorrect and misleading impression on the part of his Parliament and his Government and his country to try to work out a medical-care plan.

I may say that Mr. Sutch did not give me the impression that he thought the New Zealand plan was a perfect plan. He gave me the distinct impression that there were many difficult problems that he had had to work with in framing the original law and its administration, but that they had tried to do in their country that which was consistent with the problems that they had, recognizing that it was a small country, a country that doesn't have the great mobility that we have in the United States or the great streams of income, and he felt that they tried to work out a plan which was consistent with their background and their thinking and their financial and economic conditions.

Senator DONNELL. At any rate, Mr. Cohen, you did understand that he had been a proponent of this bill when it was put through the Parliament over in New Zealand? You understood that from your conference with him very soon, did you not?

Mr. COHEN. I understood——

Senator DONNELL. Did you?

Mr. COHEN. Yes, sir; in the sense that he was one of the technical persons advising the Minister, not a proponent in the sense of an outsider advocating the legislation.

Senator DONNELL. Very well. Now how long did this conference last on February 14?

Mr. COHEN. I would say, Senator, about 2 hours.

Senator DONNELL. Did you take any notes during the progress of the conference?

Mr. COHEN. Yes, sir; I think we took some notes.

Senator DONNELL. Well, do you know whether you did?

Mr. COHEN. I don't, Senator, because in looking back in my files, I find no notes.

Senator DONNELL. You don't find any notes in your file?

Mr. COHEN. No, sir.

Senator DONNELL. Well, weren't you accustomed to keep your notes on important matters at that time?

Mr. COHEN. Generally so, sir; although usually I dispose of them immediately after the need has been dispensed with—I mean the conference was over.

Senator DONNELL. Well, do you have any actual recollection of taking any notes at all during this conference with Mr. Sutch?

Mr. COHEN. Some; yes, sir.

Senator DONNELL. You took some notes?

Mr. COHEN. Yes.

Senator DONNELL. Well, did you sit down at your desk and take them on a pad of paper, or how did you take them?

Mr. COHEN. Yes, sir; we were sitting. Mr. Sutch was at a table and I believe there were some other tables in the room, and I have the distinct impression of jotting down a few notes on a piece of paper.

Senator DONNELL. Do you remember on what you took notes, on what particular topics you made notes with respect to it, at that conference?

Mr. COHEN. No, sir.

Senator DONNELL. Just what do you remember?

Mr. COHEN. No; I don't remember.

Senator DONNELL. You said you had the distinct impression. Do you actually have any recollection at all of taking any notes?

Mr. COHEN. Yes, sir; I have the distinct impression.

Senator DONNELL. I am not asking your impression. I am asking for your recollection.

Mr. COHEN. My recollection is that I did, sir.

Senator DONNELL. Did Mr. Fisher take any notes?

Mr. COHEN. I couldn't say, sir.

Senator DONNELL. Did you take your notes on a pad of paper that you brought with you?

Mr. COHEN. I believe that I did not bring any pad of paper with me and that I asked Mr. Sutch to give me a piece of paper.

Senator DONNELL. Do you remember now of asking Mr. Sutch for the piece of paper?

Mr. COHEN. I think I did; yes, sir.

Senator DONNELL. Did you take more than one sheet full of notes?

Mr. COHEN. I couldn't say, Senator.

Senator DONNELL. You don't remember whether you did or did not. Do you remember anything about the size of the sheet you were taking notes on?

Mr. COHEN. I had the impression——

Senator DONNELL. Please don't give us your impression. Give us your best recollection, if you will; distinguish between the two. What do you actually remember?

Mr. COHEN. They mean the same to me, Senator. My recollection is that I did take notes on a piece of paper approximately 8½ by 11 in size.

Senator DONNELL. About 8½ by 11; all right. How many pages of typewritten matter were there in the statement which Mr. Fisher ultimately prepared after this conference?

Mr. COHEN. The typewritten document consists of 12 pages, I believe, triple space.

Senator DONNELL. Twelve typewritten pages of triple space?

Mr. COHEN. Yes, sir.

Senator DONNELL. And you don't remember Mr. Fisher actually taking any notes at all?

Mr. COHEN. My recollection is that he did, Senator, but I don't want to say definitely.

Senator DONNELL. I thought a while ago you didn't recall whether he did or didn't?

Mr. COHEN. My recollection is that I think he did.

Senator DONNELL. Did you tell him to take notes?

Mr. COHEN. No, sir.

Senator DONNELL. Do you think he did take some notes?

Mr. COHEN. I think so.

Senator DONNELL. Do you have any idea how many notes he took?

Mr. COHEN. No, sir.

Senator DONNELL. Did you ever find any notes of his in your files at any time since then?

Mr. COHEN. No, Senator.

Senator DONNELL. And your own files do not contain any of the notes that you took?

Mr. COHEN. No, Senator.

Senator DONNELL. Now you say this conference took about 2 hours?

Mr. COHEN. Yes, Senator.

Senator DONNELL. Was Mr. Fisher there all the time?

Mr. COHEN. All the time.

Senator DONNELL. Was anybody else there besides you and Mr. Fisher and Mr. Sutch?

Mr. COHEN. No, sir.

Senator DONNELL. Is Mr. Fisher a shorthand reporter?

Mr. COHEN. Not that I know of, sir.

Senator DONNELL. Are you?

Mr. COHEN. No, sir.

Senator DONNELL. Now when you got back to the office, how soon after that was it that this, did you say, 12-page, triple-spaced document was prepared? How soon afterward did the preparation take place?

Mr. COHEN. It is dated on the top February 19, 1946, and our conference was on the 14th. So that would be 5 or 6 days later that it was completed.

Senator DONNELL. It was completed 5 or 6 days later. Do you know when it was begun?

Mr. COHEN. I believe it was begun almost immediately, for this reason, Senator: On the way back, Mr. Fisher and I came back together. It took maybe 20, 25 minutes or so on the return to our office.

Senator DONNELL. How did you go; did you walk or ride; do you remember?

Mr. COHEN. I don't remember, Senator.

Senator DONNELL. You don't remember that?

Mr. COHEN. No.

Senator DONNELL. How did you get over there? Do you remember that?

Mr. COHEN. No, Senator.

Senator DONNELL. But you remember that piece of paper was about 8½ by 11 inches. You recall that?

Mr. COHEN. That is the impression in my mind; yes, Senator.

Senator DONNELL. How far is it from your office to the UNRRA office?

Mr. COHEN. At that time we were located in a different building, if I remember correctly.

Senator DONNELL. Don't you remember where you were located at that time?

Mr. COHEN. I am trying to remember the specific date. I think we were located at 1825 H Street, and I would say that is, oh, a 15- or 20-minute walk, perhaps, from the UNRRA building.

Senator DONNELL. Well, are you sure you were actually located at 1825 H Street at that time, or are you just giving us your best recollection on that?

Mr. COHEN. I believe that we were——

Senator DONNELL. I didn't ask you that. Are you sure whether you were or not?

Mr. COHEN. I am not sure, Senator. I don't keep all those little details in my mind.

Senator DONNELL. You don't keep the little details of where your office was in your mind?

Mr. COHEN. Senator, if you had to move around as much as we bureaucrats have [laughter]——

Senator DONNELL. There are those who advocate further moving of some of the bureaucrats, too. [Laughter.] At any rate, regardless of that, Mr. Cohen, you got back over there and you were about to tell us why you think the preparation of the statement was not entered upon after you got back.

Mr. COHEN. Yes, sir.

Senator DONNELL. Do you have any actual recollection of when it was started?

Mr. COHEN. Well, in the sense of starting it, in the sense of the process beginning in our minds, it began as we returned from the conference in Mr. Sutch's office, because Mr. Fisher and I began to discuss immediately the elements that were to go into this draft at the time that we left Mr. Sutch's office, which we prepared in accordance with his request.

Senator DONNELL. But you don't remember whether that discussion took place as you walked or as you rode?

Mr. COHEN. Now as we are having this discussion and my mind is refreshed on it, it seems quite clear to me that we walked back.

Senator DONNELL. And you discussed this matter as you walked back down the street?

Mr. COHEN. I think so, sir.

Senator DONNELL. And when you got back, had you pretty well outlined what the general scope of the statement was to be that was to be prepared?

Mr. COHEN. Well, sir; here is the main point about it: Mr. Sutch in his discussion was very detailed and very precise in his observations about the plan. There is nothing in this statement which does not represent in essence items, matters or facts or opinions that were Mr. Sutch's during the course of our 2-hour discussion. There was very little need for us to do any further work. In fact, I will say to you, Senator, that after I returned, Mr. Fisher returning together with me walking, I don't believe I discussed the matter again with Mr. Fisher, because it was very clear, I believe, to him and to me exactly what Mr. Sutch's opinions and views were, and it was merely a matter of sitting down and writing or dictating them to reflect what he had said.

Senator DONNELL. And Mr. Fisher was the man who did the sitting down and writing or dictating?

Mr. COHEN. Yes, sir.

Senator DONNELL. Did you dictate any of this 12-page statement?

Mr. COHEN. No, sir.

Senator DONNELL. Mr. Fisher dictated all of it?

Mr. COHEN. Yes, sir.

Senator DONNELL. You didn't hear him dictate any of it?

Mr. COHEN. No, sir.

Senator DONNELL. Do you know to whom he dictated?

Mr. COHEN. No, sir.

Senator DONNELL. You didn't see him dictating?

Mr. COHEN. No, sir.

Senator DONNELL. Where was the UNRRA building?

Mr. COHEN. The UNRRA building is up at Dupont Circle. I believe it is called the Dupont Circle Apartments. It was formerly an apartment house.

Senator DONNELL. I see. And as you walked along down from Dupont Circle to 1825 H Street, it was there that you carried on this conversation—as you were walking along down the street on February 14. Is that right?

Mr. COHEN. Yes, sir.

Senator DONNELL. And you never saw any more of the whole thing until after it was all finished?

Mr. COHEN. Oh, no, Senator.

Senator DONNELL. At any rate, I am asking you that. Is that a fact?

Mr. COHEN. No, sir; when Mr. Fisher had completed the material, it was sent to me by his supervisor, Mrs. Merriam in the memorandum dated March. No, I am sorry. That is incorrect. It was sent to me by Mr. Fisher.

Senator DONNELL. Sent to you by Mr. Fisher?

Mr. COHEN. Yes, and I went over it prior to the time that he submitted it to Mr. Sutch.

Senator DONNELL. All right. Now after you got back from this conference of February 14, did you dictate a letter right away to Mr. Falk?

Mr. COHEN. I dictated a memorandum the next day; it must have been February 15.

Senator DONNELL. Well, why didn't you dictate it right away when you got back?

Mr. COHEN. Well, I couldn't give you the answer other than perhaps there was a lot of other pressing business, Senator, and I took what work I had to do in the order of its priority. It is my usual practice.

Senator DONNELL. In the course of this letter of February 15, you say this: "He," that is, Mr. Sutch, "agreed to make such a statement." Did you ask him to make the statement or did he volunteer it?

Mr. COHEN. He volunteered to make the statement, Senator.

Senator DONNELL. Why didn't you say so in here that he volunteered. Here you say, "He agreed to make the statement." Did you ask him if he agreed to make it?

Mr. COHEN. Well, after he volunteered to make the statement, I stated that I thought Senator Murray would be delighted to have such a statement.

Senator DONNELL. Then he agreed. You mean that he volunteered?

Mr. COHEN. Yes, sir.

Senator DONNELL. All right. [Reading:]

> He agreed to make such a statement, providing that we would make a first draft of what it is we wanted to say which he wanted to go over.

Did you write that to Mr. Falk?

Mr. COHEN. That is what I wrote in this memorandum, Senator.

Senator DONNELL. You sent it to Mr. Falk, as it appears in this memorandum, did you not?

Mr. COHEN. Yes, sir. However, Senator, I think that statement in there has been misunderstood.

Senator DONNELL. What does it mean other than what it says?

Mr. COHEN. Well, Senator, I didn't write this memorandum at the time as an attempt to be so exact that it would only be possible of one interpretation. I had no idea that it would ever become so prominent in public discussion that every word would be looked upon as having a specialized meaning. My intent was that Senator Murray had asked us to prepare a brief statement of the charges concerning the New Zealand plan, and I presumed, as I always have in my 12 or 13 years in legislative work up here on Capitol Hill, that the Senator likes a rather brief, concise, and pointed statement, because he is a busy man, and what I intended to say there was that there should be in the statement those essential points that bore directly upon the charges and countercharges in the New Zealand plan. In the course of the discussion with Dr. Sutch, we discussed many other matters that are not contained in this memo. We went into the question of the eligibility provisions and the details of financing and how they collected the contributions, that are not touched upon in this memo whatsoever.

Senator DONNELL. That isn't what I am asking you, Mr. Cohen. I am asking you about the meaning of this sentence. You said that you think it hasn't been interpreted as to just what it does mean, or words to that effect. Now it says [reading]:

> He—

that is, Mr. Sutch—

> agreed to make such a statement providing that we would make a first draft of what it was we wanted to say.

Is that true? Is that what Mr. Sutch said?

Mr. Cohen. Yes; that is a correct statement of what Mr. Sutch said, in this sense. Mr. Sutch says [reading]:

> Now I can talk for hours about the New Zealand plan. What is it that you want to have in the statement that will bear directly upon the controversy that exists here in the United States—

and my words, "what we wanted" meant what were the essential elements that should be stressed in the memorandum that were in response to Senator Murray's inquiry. I assumed Senator Murray did not want a book about all the operations of the New Zealand plan. He wanted something that was on the certain essential points that he was concerned with, and I was trying to comply during that time with the request of the Senator.

Senator Donnell. Now Mr. Fisher, as Mr. Falk said today, was not a man who had specialized along the line of health insurance, was he?

Mr. Cohen. No, sir.

Senator Donnell. He knew, as Mr. Falk said, and I think I am correctly quoting him, in substance, he knew just about what, generally speaking, people would know who were not specializing, but know about in his department.

Mr. Cohen. Yes, sir.

Senator Donnell. And Mr. Fisher, after this 2-hour conference, proceeds here to a 12-page statement to be submitted to Mr. Sutch. Is that right?

Mr. Cohen. Yes, sir. I don't think that is unfair, Senator, because he was repeating in here the statements and observations made by Mr. Sutch. That is not such a difficult task.

Senator Donnell. Did you give your notes to Mr. Fisher?

Mr. Cohen. I couldn't say "Yes" or "No" to that, Senator.

Senator Donnell. Do you have the photostatic copy of all of the entire 10 or 12 pages?

Mr. Cohen. Yes, sir.

Senator Donnell. Now I notice on the first page here that there are five different points that are set forth in this statement prepared by Mr. Fisher for Mr. Sutch, with which Mr. Sutch is supposed to have been struck, the five different criticisms: First, that the New Zealand health benefit program is socialized medicine; second, that it has resulted in a deterioration in the quality of medical care; third, that it alleges unreasonable patient demand on the time of the doctor; fourth, that it has been abused by the doctor; five, that it faces failure and bankruptcy.

Do you know whether you made notes of all these five points that you had worked on in Mr. Sutch's quarters?

Mr. Cohen. No, Senator, because it is my recollection, to the best of my knowledge, that those were the five points that were made in these articles that had been criticizing the New Zealand plan. These were not points which Mr. Sutch made. They were the criticisms that were made against the New Zealand plan to which he directed his comments.

Senator DONNELL. I understand that, of course. That is what he said, that he had been struck by the character of some of the criticisms, and then these five are listed. Now what I am asking you is: Did your notes set forth those five different points with the character of which Mr. Sutch had told you he had been struck?

Mr. COHEN. I think that those were the five points that we discussed in our conversation, Senator.

Senator DONNELL. I was asking whether or not those were listed in your notes, if you recall?

Mr. COHEN. I couldn't remember, Senator.

Senator DONNELL. You couldn't remember that?

Mr. COHEN. No.

Senator DONNELL. Now this proceeds in great detail here. It apparently takes up the statement, that [reading]:

> He was an economic adviser to the New Zealand Labor Minister for years and helped draft the program and get it under way. What I have to say about these charges may be of some interest to you, but first a few words on the program itself.

Then that is all stricken out here. Evidently Mr. Sutch struck all that out. Do you know whether or not you had made any notes about the particular position that Mr. Sutch had had during all these years from which that paragraph was prepared?

Mr. COHEN. No, Senator, but I do remember very distinctly that that is what he said in the course of his discussion. He told us at great length of his participation in the formulation of this program.

Senator DONNELL. Then this proceeds along in great detail here. It is quite remarkable, it would appear to me, for a man to retain all this in his mind after this 2-hour conference and, just having had the benefit of this little conference, walk down the street with you in the meantime. It says [reading]:

> New Zealand health benefits include treatment by a general practitioner at home or office, hospital care, treatment in the out-patient department of the hospital, maternity care, pharmaceutical prescriptions, X-ray, diagnostic services, physical thereapy, and visiting nurse services. These services are free to all members, but in the field of education individuals are at liberty to make their own arrangements, and some do, in fact.

Do you mean to say Mr. Fisher had notes that you never saw anything written by him or yourself, that would go into all that detail as to what the New Zealand system was?

Mr. COHEN. No, Senator, I didn't imply that in my statement.

Senator DONNELL. Do you think that he or you could remember all these different things I have read here after your 2-hour conference?

Mr. COHEN. Why, certainly, Senator. There is nothing novel in that statement about what the character of the benefits of the New Zealand plan are.

Senator DONNELL. You think you would remember all these different items as listed there after your conference?

Mr. COHEN. You might have to check up on it to see whether you knew every one, but that is purely a factual statement which, to the extent that you couldn't remember it, could be very easily verified by reference to the law.

Senator Donnell. All I am asking is, Do you think it was possible for any individual to go there in a 2-hour conference with Mr. Sutch and, regardless of whether he had some brief notes or not, come out of there with 12 pages, triple spaced, as you say, going into very considerable detail, obviously, and have all that communicated to him by Mr. Sutch, and remember it all in sufficient detail to dictate it back to the office? Do you think that is possible?

Mr. Cohen. Yes, Senator, when you take into account the fact that both Mr. Fisher and myself went there with some considerable knowledge about the New Zealand system. We did not go to that session completely blank. We knew, I hope we did, a considerable amount of information about the New Zealand plan, and, together with what Mr. Sutch said, we were able to pretty correctly on short notice present an accurate picture of the facts about the New Zealand system. We pride ourselves, Senator, in our office in trying to keep abreast and know about these developments in these different countries, particularly in view of the fact that the New Zealand system is so novel and so distinctive and it has been the subject of so much discussion in professional journals and in the public press. I had, in order to comply with Senator Murray's request, just finished reading a considerable number of documents, and as I told you, I had read the law itself. So I felt that I went there pretty well prepared on the New Zealand system.

Senator Donnell. Mr. Fisher, however, as has been indicated here, was certainly not to be considered an expert on the subject of health insurance, was he?

Mr. Cohen. No, Senator.

Senator Donnell. And this letter here, that was submitted back to Mr. Sutch, is relating to the subject of the health benefit program, with its particular application to this alleged socialization of medicine, alleged deterioration in the quality of medical care, alleged unreasonable patient demand on the time of the doctor, alleged abuse by the doctor and alleged failure and bankruptcy, and you think, do you, that when Mr. Fisher prepared this statement for submission back to Mr. Sutch, that he was simply repeating what Mr. Sutch had said, rather than incorporating in large part the ideas that you gentlemen had yourselves and were thinking, as you have said in your letter here, "is what we wanted to say"?

Now isn't it a fact, Mr. Cohen, that you did thereafter talk to Mr. Sutch and got his general ideas, that you went back and you delegated to Mr. Fisher the duty of preparing the statement, which would, as your letter to Mr. Falk says, "set forth what we want to say"? Then you sent that back to Mr. Sutch, and he was going to be charged with the privilege of changing it in any way that he wanted, but it was to evidence what you gentlemen wanted to say? Isn't that a correct statement of fact?

Mr. Cohen. Well, Senator, all I can say in all honesty and fairness is, as I said to you before, there was no intention in my mind before we went to the meeting with Mr. Sutch to formulate any specific statement or to obtain from him any written document on this matter. So that I could not have gone to the meeting with any plan in mind as to what we wanted to say. But after his statement, after his volunteering of this information and our discussion for nearly 2 hours, then it appeared that out of that material could be made a brief statement which would be what Senator Murray had asked us for.

Senator DONNELL. By brief statement, you mean 12 typewritten, triple spaced pages?

Mr. COHEN. Yes, sir. I consider that a brief statement on the New Zealand law. When you consider that the tomes that are written on these documents are 200, 300, or 400 pages, I consider that a very brief memorandum.

Senator MURRAY. That is very brief, I think, when you consider that sometimes the Senators will talk for 2 days on a clause of the Constitution.

Mr. COHEN. Senator, if I may, while we are waiting——

Senator DONNELL. We are not waiting. Go right ahead.

Mr. COHEN. I would like to say that while Mr. Falk was on the stand, he referred to some of the statements I had made to him regarding this matter, and for the sake of the record, I would prefer, and perhaps you would, to have my own statement in my own words in the record in one place concerning this matter. I have written it out in two pages in full.

Senator DONNELL. Will you go ahead and give it to us, please?

Mr. COHEN. Would you like me to read it?

Senator DONNELL. Yes, sir.

Mr. COHEN. It is a repetition of a large part of what I have already said, but it is somewhat, perhaps, better organized.

Senator SMITH. Let me just ask at this point, is this a statement you prepared at the time that you made this report to Mr. Falk?

Mr. COHEN. Since then.

Senator SMITH. You prepared this since then?

Mr. COHEN. Yes, sir.

Senator SMITH. So that you could prepare a clear statement, then, of your conversation?

Mr. COHEN. Yes, Senator. When I first saw this material in the Medical Economics and the rather gross misrepresentations, in my opinion, of my participation in this, and the rather colorful language that was used about my participation, such as the fact that it was "a masterpiece of indignation by proxy" and that this was a "maneuver" and that "Falk and Cohen planned to draw up their own statement of 'what it was wanted to ask' and then have Mr. Sutch to sign it," I felt I had better set down for Mr. Falk's record and my own a truthful account of what had transpired, because this statement in Medical Economics, in my opinion, is quite a distorted picture of what actually occurred, what was in my mind and what I think was in Mr. Sutch's mind at the time.

Senator DONNELL. When did you prepare this statement you are about to read, Mr. Cohen?

Mr. COHEN. I would say a few weeks ago.

Senator SMITH. Go ahead and read it.

Mr. COHEN. During the course of the hearings on S. 1606, Senator Murray, chairman of the Senate Committee on Education and Labor, several times requested material on the operation of the New Zealand medical-care program. He had read certain criticisms of the New Zealand program in newspaper articles and in material published by the American Medical Association. He specifically asked me orally one day whether we had been able to furnish him any factual material or opinion relating to the operation of the New Zealand plan and any refutation of the charges made concerning the failure of the New Zealand program.

Shortly thereafter I was informed that Dr. W. B. Sutch, then an official of UNRRA, who had been intimately connected with the formulation and administration of the New Zealand plan, was in town. I made an appointment to see Dr. Sutch at his UNRRA office and took Mr. Jacob Fisher with me because of his knowledge and study of the New Zealand plan. The purpose of my going to see Dr. Sutch was to have a general discussion with him and to get factual information and his viewpoint on the various matters which were being criticized in the New Zealand program.

In discussing this matter with Dr. Sutch, I referred to the articles published in the United States, and he was extremely indignant about them, stating that they were half-truths, erroneous, and based on misunderstanding of the New Zealand situation. Dr. Sutch stated that if he were going to remain in the United States a little longer, he would write a statement giving a true picture of the New Zealand program and refuting the criticisms being circulated. I then mentioned to Dr. Sutch that the chairman of the Senate committtee, Senator Murray, had requested us for information on the New Zealand plan and if he had time to prepare a statement giving his views, I was sure Senator Murray would be very glad to receive them.

Dr. Sutch indicated he personally did not have time to prepare a statement then, as he was leaving the United States, but he would be very glad to discuss his views with Mr. Fisher and me in some detail, and he requested that if at the conclusion of our discussion we would write up his views, he would be glad to review and revise them, sign the statement and send it to Senator Murray.

Mr. Fisher and I then discussed the New Zealand situation at some length with Dr. Sutch, going into detail with respect to the technical aspects of the New Zealand plan. Dr. Sutch gave us a detailed explanation as to how various provisions of the New Zealand plan worked, and various comments on the provisions in the New Zealand law and their financing and administration. After an extended conversation on numerous points, we agreed to comply with Dr. Sutch's request and prepare a rough draft of the statement, embodying the views he had expressed in our discussion.

I asked Mr. Fisher, who was familiar with the technical terminology and the technical details of the New Zealand plan, to prepare a rough draft based upon Dr. Sutch's statements, comments, and opinions. Mr. Fisher prepared such a statement, which was sent to Dr. Sutch in rough draft. Dr. Sutch read and reviewed the statement, edited it, made certain deletions, additions and changes, agreed that the statement represented his views without any qualification whatsoever and said that he wished to have it transmitted to Senator Murray.

In view of the fact that he was leaving town, he sent the revised statement as approved by him to me, and asked that we send him several copies of any document which was printed.

Senator Donnell. Now, Mr. Falk, I understand that when you were presenting the photostatic copy this morning, referring to this incident with Mr. Sutch, showing the changes that he had made, that you were going to introduce the complete photostatic record of that matter.

I take it that you are going to give us the completed draft also as it appears. Is that right?

Mr. Falk. Yes, sir. I understood that.

(The material referred to is as follows:)

Mr. Cohen's Statement Re Sutch Statement

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In view of the fact that he was leaving town, he sent the revised statement as approved by him to me, and asked that we send him several copies of any document which was printed.

Federal Security Agency,
Social Security Board,
Washington, February 15, 1946.

To: Mr. I. S. Falk.
From: Wilbur J. Cohen.
Subject: New Zealand Medical Care Plan.

I had an appointment yesterday with Dr. W. B. Sutch, formerly of the New Zealand Ministry of Finance, who is now working with UNRRA. I took Mr. Fisher with me to talk with him. Dr. Sutch was intimately connected with the formulation of the medical-care plan in New Zealand, he knows the New

Zealand Minister of health very well, and also knows Dr. Robb. During the conversation I asked him whether he had any statement on the New Zealand medical plan which might be used to prove that the statements made by the American Medical Association concerning the failure of the New Zealand system were false. When I showed the AMA statements to Dr. Sutch he was very indignant and said he would be willing to send a statement saying that they were false. He agreed to make such a statement providing that we would make a first draft of what it was we wanted to say which he would go over. I told him that if he made such a statement we could use it by including it in the committee prints of the Senate Education and Labor Committee.

I have asked Mr. Fisher[1] to draft such a rough statement to give to Dr. Sutch. We will have to get it to him by next Tuesday or Wednesday, since he is leaving the country shortly.

WILBUR J. COHEN

Copies to Mrs. Merriam and Mr. Fisher.

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[1] Drafted February 19, 1946; filed separately.

UNITED NATIONS RELIEF AND REHABILITATION ADMINISTRATION,
Washington 25, D. C.

Mr. WILBUR J. COHEN,
Social Security Board,
Washington 25, D. C.

DEAR MR. COHEN: I am enclosing my revision of the social-security statement. You will note that I have not made many changes. I would appreciate your letting me have several copies of any document which is officially printed. Would you kindly send them to me at the following address: Dr. W. B. Sutch, care of UNRRA, 52 William Street, Sydney, Australia.

I have included a brief biographical note from which you can take extracts, but I would not like you to make additions.

Best wishes.

Yours sincerely,

W. B. SUTCH.

(Enclosure.)

(The words crossed out represent deletions; words in italics mean matter attributed to Mr. Sutch's corrections.)

~~2/19/46~~
3/13/46

~~Draft~~ STATEMENT ~~for~~ *by* MR. W. B. SUTCH[1] OF NEW ZEALAND

During my present stay in the United States, I have been struck by the character of some of the *unwarranted* criticisms levelled against the New Zealand health benefit program, viz:

1. That it is "socialized" medicine.
2. That it has resulted in a deterioration in the quality of medical care.
3. That it has led to unreasonable patient demands on the time of the doctor.
4. That it has been abused by the doctor.
5. That it faces failure and bankruptcy.

~~As an economic adviser to the New Zealand Labor Minister for years and one who helped draft the program and get it under way, what I have to say about these charges may be of some interest [to you]. But first a few words on the program itself.~~

New Zealand's health benefits include *free* treatment by a general practitioner at home or office, hospital care, treatment in the out-patient department of a hospital, maternity care, pharmaceutical prescriptions, X-ray diagnostic services, physical therapy ~~and~~ visiting nurse service *and part payment of specialists fees.* These services are free to all members of the public, but as in the field of education, individuals are at liberty to make their own arrangements and some do in fact.

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[1] Director, Procurement and Shipping, Southwest Pacific Area, UNRRA. Former Economist to the Minister of Finance, NZ Govt.; member of the NZ delegation to the Imperial Conference, 1936, of the NZ delegation, League of Nations, 1937; author, the Quest for Security in New Zealand, 1942, Poverty & Progress in NZ, 1941.

When I say the benefits are free I do not imply thereby that someone is getting something for nothing. The money to pay for the benefits comes out of the Social Security Fund, which is financed largely by a special social security tax on the income of every income receiver in the Dominion. The money thus raised goes in part to pay the fees to doctors, hospitals, nurses, pharmacists, etc. who elect to participate in the scheme. Practically all do.

Now as to the charges made against the New Zealand system.

First, that it is "socialized" medicine. ~~[Frankly I don't know what the term means].~~ If ~~[that]~~ *this charge* is another way of saying that New Zealand has State medicine, then the critics had better take a closer look at us. State medicine is the provision of health services to the general public by salaried practitioners paid by and under the direction of the government. Most countries have some State medicine Even the United States *has it*—your public general hospitals and clinics for the poor, your tuberculosis and mental-disease hospitals, for instance, or your free medical service to veterans through the Veterans' Administration and for merchant seamen through the marine hospitals of the United States Public Health Service.

The New Zealand health benefit program is not State medicine because the overwhelming majority of doctors still make their living from patients' fees. This is your present system here. *In New Zealand* with the exception of a handful of physicians in sparsely settled areas, who are on salary, and another small group who prefer to be paid so much per person per year under their care (capitation payments), the ~~New Zealand~~ general practictioner derives his income from fees charged for services rendered. The only difference from the common practice in your country is that the fee is paid by the Social Security Fund, rather than by the patient, or is repaid by the Fund if paid by the patient. The doctor is free to ~~charge~~ *arrange with the patient that he pay* an additional fee, ~~to the patient,~~ and some in fact do; ~~although~~ *it is my impression, however, that* the ~~great~~ majority of doctors by and large abide by the general purpose of the health benefit system and confine their charges to the *liberal* amount paid by the social security fund. And let me add that I think that most of them prefer that to the old arrangement under which the doctor ~~is always~~ *tends to* assess~~ing~~ the ability of the patient to pay fees, soaking the rich where he can, giving free service to the very poor and being generally unhappy about the whole business because his training makes him a doctor and not a tax assessor or a real estate appraiser.

Now the general purpose of the system—and this brings me to the heart of the matter—is simply this, to make sure that people in need of medical care can get it, irrespective of their economic circumstances. New Zealand decided in 1938, when we passed our Social Security Act, that the health of the people is as much a public concern as education or fire protection; and that like education and fire protection, health services should be available to all. Now there are several ways to get health services to the people. One way is the hit-or-miss, catch-as-catch-can method in effect in most countries and such as we had. That we found to be unsatisfactory. Another is state medicine—all doctors on the Government pay roll. A third method and the one we chose was the creation of a fund, to which all would contribute on the basis of their ability to pay, and out of which we would pay the doctor, the hospital, the nurse, and the dispenser of drugs, for services and materials rendered as people need them. This is the system we have. All contribute, through a 5-percent social security tax on income; all benefit, by applying for and getting health care as they need it. The arrangement is in effect merely a pooling of risks, since all of us, including the healthiest, have occasion to see a doctor or to use a hospital at some time or other and it makes no sense to deprive some of us of medical care simply because we do not have the money to buy it at the particular time we need it.

Today everybody in New Zealand has access to medical care. Though many *medical and organizational* problems remain to be solved~~—and they are many—~~ that is the outstanding fact about our health-benefit program. In spite of wartime shortages of doctors and nurses, it has meant more health services to more people than at any time in our history. That is progress, and progress in the right direction, and although I for one would like to see more group practice and less individual practice, more emphasis upon the organization of district health centers and less upon the maintenance of the status quo, I cannot help but recognize that in its aim to remove considerations of cost from the receipt of medical care, the Government has been successful.

Now as to quality of care. Quality is hard to measure. I don't want to pass judgment on the quality of health services in New Zealand today. I am not a

~~doctor~~ *medical man.* Speaking as a layman, however, I wish to point out that the whole case for the alleged deterioration in the quality of care rests upon the assumption that we have had a wholesale reorganization in the pattern of medical practice. That assumption has no basis in fact. Our doctors are the same doctors we had in 1940, ~~prior to~~ *before* the establishment of the medical benefit. Patients still choose their own doctors. Doctors are still free to accept or reject patients. What they do with patients, short of malpractice, is still their own professional concern. Hospital boards still run their own institutions and drug dispensers their own establishments. The only difference from the old arrangement is the source of the money for payment. Why this should make any difference with respect to the quality of service rendered is a complete mystery to me and I am sure to any impartial observer.

It is true~~, of course,~~ that ~~some~~ *a few* doctors, ~~not many I think,~~ have *probably* taken advantage of the security of income afforded by the Fund to go in for over-~~visiting of~~ *consultation with* patients. That is bad. No one defends it. The government, I may say, is well aware of this ~~abuse~~ *fact* and is discussing with the New Zealand Branch of the British Medical Association what should be done about ~~it~~ *these few doctors whose actions may not be in accordance with professional ethics.* Where, as in both New Zealand and this country, the number of patients to be seen and the frequency of revisits is left strictly to the professional judgment and private conscience of the doctor, it is difficult to prove abuse. Responsibility for proper policing is not wholly the government's, I may add. The profession, too, has a responsibility.

~~Before leaving the subject of doctor abuse of the system,~~ I want to say a word about the related subject of doctor income. One of the more frequently heard objections to any kind of rational reorganization of health services is the alleged effect upon the doctor's economic rewards. He will make less money, it is said, and because he will make less money, the argument goes on, his incentive to give the best that is in him will be seriously impaired. This comment is not, of course, particularly flattering to the doctor; but assuming it to be true, what are the facts? The fact is that never before in the history of the Dominion has doctor income been so high, never before have the economic rewards for the general practitioner been quite so attractive. The combination of opportunities to render medical service unhampered by patient ability to pay *plus* a guaranteed payment per service, ~~and the unavailability as yet of specialist services~~ has served to put the medical profession in New Zealand nearer the top of the economic pyramid than in any other country. ~~That is not necessarily a good thing. Some of us feel that the relatively easy money rewards in general practitioner service have kept promising young men out of specialties to which they could make a valuable contribution, and out of hospitals and laboratories that could use their skills and talents. Here is a situation that obviously calls for correction.~~ It is the opposite~~, however~~ of what some of the critics of health benefits have feared. Doctors have not ~~gotten~~ *become* poorer. If anything, ~~some of them have gotten too rich.~~ *the medical profession is getting too great a share of the national income.*

The other kind of abuse to which it is said our system lends itself may now be mentioned—unreasonable patient demands on *a* doctor's time and effort. There is some of that, too; not as much however as observers 10,000 or more miles away think they see. Of course there are *a few* neurotics in New Zealand, as there are in this country, too. They *may* pester the doctor for trivial or imaginary ailments. They are overanxious about a condition very well in hand from a professional point of view. If they think their present doctor is unsympathetic to their needs as they see them, they go to another. They shop around. This is no new problem. We had such people before. You have them now. ~~The significant question is, has the number of such people gone up? My impression is that it has, but not to the extent that the temptations for neurotic behaviour would have led one to expect.~~ The problem, *however, is minor and* is one of proper administration. Regulations have been issued, the effect of which is to spot the hypochondriacs and support the doctor in his refusal to give more service than the situation warrants. Some of these neurotics, I may mention in passing, are really emotionally or mentally unwell, and need more rather than less medical attention. ~~But not by a general practitioner. They need psychiatric care, and when we get specialists' services provided under our system, including psychiatry, we may be able to do something for them besides complain about them.~~

You ~~may~~ *will* have gathered from all I have said that the intervention of the government in the relations of doctor and patient, hospital and patient, and pharmacist and patient, is restricted to the economic sphere. The government pays the bill. It doesn't tell the doctor how to practice medicine or the pharmacist how to compound prescriptions. Of bureaucracy, therefore, if I may use that much-abused word, there is relatively little, and I mention it not because it is an issue in New Zealand, but because I understand it has become one in this country, however imaginary it may be in relation to our system.

Lastly, a word about the bankruptcy which the Journal of the American Medical Association says stares us in the face. We finance our ~~whole~~ social security program, as I've said, out of the receipts of a 5-cent tax on ~~gross~~ income. This source is supplemented by a governmental contribution out of general revenues. ~~The income~~ *This* tax, since the beginning of the program, has provided about three-fourths of the receipts of the Fund; a registration fee about 3 percent; and the government contribution the balance. Most of the Fund's expenditures are for cash benefits for the aged, widows, orphans, invalids, the sick and unemployed, and for our children's allowance scheme. The health benefits last year represented about 30 percent of the Fund's expenditures; and administration, including the cost of tax collections, about 3 percent.

Since the fiscal basis of the social security program—cash benefits and health benefits together—rests upon taxes, and these are geared to yield enough to pay the benefits, the case for the charge of bankruptcy rests in the last analysis upon the ability of the national economy to pay these taxes. About that, there is not in my opinion any question. Unless we go into an economic tailspin which will curtail our whole standard of living, what we put aside out of current income will suffice to meet our obligations for cash benefits and health benefits. *New Zealand's policy of full employment will ensure this.*

Only a few months ago *in order to meet expanded pension payments which are now in operation* Parliament strengthened ~~our~~ *the* fiscal base by raising the social security tax from 5 to 7½ percent, effective later this year. We were enabled to do this by reducing our national security or war ~~income~~ tax from 7½ to 2½ percent, which means a net saving to taxpayers for both taxes combined of 2½ percent. We spent hundreds of millions of pounds for the war, much of it out of increased taxes; we think it will not be too difficult to find 5 million pounds for health benefits. It is worth at least that much to us in the improved health and well-being of our people.

Our system of health benefits is still young in New Zealand. It has problems and it is experiencing the usual growing-pains. It has had to meet special difficulties because of the war. But it stood up under the trying conditions of war-time; and we haven't the slightest doubt that it will gain strength and efficiency in the next few years. *And, whatever the government in office—for the opposition party also subscribes to social security—the system is here to stay.*

~~BIOGRAPHY~~

~~Dr. W. B. Sutch is a New Zealand economist at present on loan to UNRRA from the New Zealand Government. working as Deputy Director for Requirements and Supply of the He is in control of procurement and shipping for UNRRA in the Southwest Pacific Area Office.~~

~~He has held various positions as economist to the Minister of Finance who introduced the social security legislation and to the Ministry of Supply in New Zealand, and has played a prominent part on the government committees concerned with changes in the organisation of New Zealand's social and economic life.~~

~~He was workers representative on the Government Railways Industrial Tribunal, which is an arbitration court to deal with railwaymens' wages and conditions. In 1936 he was a member of the New Zealand delegation to the Imperial Conference and represented New Zealand at the League of Nations in 1937.~~

~~He is a well known member of the New Zealand Institute of International Affairs, at one time being vice-president. He was a member of the New Zealand delegation to the British Commonwealth Relations Conference held at Lapstone, Australia, in 1938.~~

~~He has done a considerable amount of broadcasting in New Zealand on social and economic topics and has contributed to economic and social periodicals. His publications include the following:~~

~~Price Fixing in New Zealand.~~
~~Columbia University Press, New York, 1932.~~
~~Recent Economic Changes in New Zealand.~~
~~Institute of Pacific Relations~~
~~New Zealand Council, 1936~~
~~New Zealand's Labour Government at Work.~~
~~League for Industrial Democracy, New York, 1939.~~
~~Poverty and Progress in New Zealand.~~
~~Modern Books, Wellington, 1941.~~
~~The Quest for Security in New Zealand.~~
~~Penguin Special, London, 1942.~~
~~Good-Bye to Gold.~~
~~The Progressive Publishing Society, Wellington, 1944.~~

Federal Security Agency,
Social Security Board,
Washington, March 15, 4196.

Memorandum.
To: Mr. Wilbur J. Cohen.
From: Ida C. Merriam.
Subject: Statement by Mr. Sutch.

The revised statement on the New Zealand health-benefit program has now been typed. Mr. Fisher condensed the bibliographic sketch which Mr. Sutch sent us and we incorporated it in a footnote on the first page of the statement.

Ida C. Merriam.

Copy to Mr. Falk.

Statement by W. B. Sutch[1] of New Zealand

During my present stay in the United States, I have been struck by the character of some of the unwarranted criticisms leveled against the New Zealand health benefit program, viz:

1. That it is "socialized" medicine.
2. That it has resulted in a deterioration in the quality of medical care.
3. That it has led to unreasonable patient demands on the time of the doctor.
4. That it has been abused by the doctor.
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New Zealand's health benefits include free treatment by a general practitioner at home or office, hospital care, treatment in the outpatient department of a hospital, maternity care, pharmaceutical prescriptions, X-ray diagnostic services, physical therapy, visiting nurse service, and part payment of specialists' fees. These services are free to all members of the public, but as in the field of education, individuals are at liberty to make their own arrangements and some do in fact.

When I say the benefits are free I do imply thereby that someone is getting something for nothing. The money to pay for the benefits comes out of the social-security fund, which is financed largely by a special social-security tax on the income of every income receiver in the Dominion. The money thus raised goes in part to pay the fees to doctors, hospitals, nurses, phamacists, etc., who elect to participate in the scheme. Practically all do.

Now as to the charges made against the New Zealand system.

First, that it is "socialized" medicine. If this charge is another way of saying that New Zealand has state medicine, then the critics had better take closer look at us. State medicine is the provision of health services to the general public by salaried practitioners paid by and under the direction of the government. Most countries have some state medicine. Even the United States has it—your public general hospitals and clinics for the poor, your tuberculosis and mental-disease hospitals, for instance, or your free medical service to veterans through the Veterans' Administration and for merchant seamen through the marine hospitals of the United States Public Health Service.

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[1] Director, Procurement and Shipping, Southwest Pacific area, United Nations Relief and Rehabilitation Administration. Former economist to the Minister of Finance, New Zealand Government; member of the New Zealand delegation to the Imperial Conference, 1936; of the New Zealand delegation, League of Nations, 1937; author, The Quest for Security in New Zealand, 1942; Poverty and Progress in New Zealand, 1941.

The New Zealand health benefit program is not state medicine because the overwhelming majority of doctors still make their living from patients' fees. This is your present system here. In New Zealand, with the exception of a handful of physicians in sparsely settled areas, who are on salary, and another small group who prefer to be paid so much per person per year under their care (capitation payments), the general practitioner derives his income from fees charged for services rendered. The only difference from the common practice in your country is that the fee is paid by the social-security fund, rather than by the patient, or is repaid by the fund if paid by the patient. The doctor is free to arrange with the patient that he pay an additional fee, and some in fact do; it is my impression, however, that the majority of doctors by and large abide by the general purpose of the health benefit system and confine their charges to the liberal amount paid by the social-security fund. And let me add that I think that most of them prefer that to the old arrangement under which the doctor tends to assess the ability of the patient to pay fees, soaking the rich where he can, giving free service to the very poor, and being generally unhappy about the whole business because his training makes him a doctor and not a tax assessor or a real-estate appraiser.

Now, the general purpose of the system—and this brings me to the heart of the matter—is simply this, to make sure that people in need of medical care can get it, irrespective of their economic circumstances. New Zealand decided in 1938, when we passed our Social Security Act, that the health of the people is as much a public concern as education or fire protection; and that like education and fire protection, health services should be available to all. Now, there are several ways to get health services to the people. One way is the hit-or-miss, catch-as-catch-can method in effect in most countries and such as we had. That we found to be unsatisfactory. Another is state medicine—all doctors on the Government pay roll. A third method and the one we chose was the creation of a fund, to which all would contribute on the basis of their ability to pay, and out of which we would pay the doctor, the hospital, the nurse, and the dispenser of drugs for services and materials rendered as people need them. This is the system we have. All contribute through a 5 percent social-security tax on income; all benefit by applying for and getting health care as they need it. The arrangement is in effect merely a pooling of risks, since all of us, including the healthiest, have occasion to see a doctor or to use a hospital at some time or other, and it makes no sense to deprive some of us of medical care simply because we do not have the money to buy it at the particular time we need it.

Today everybody in New Zealand has access to medical care. Though many medical and organizational problems remain to be solved, that is the outstanding fact about our health-benefit program. In spite of wartime shortages of doctors and nurses, it has meant more health services to more people than at any time in our history. That is progress, and progress in the right direction; and although I, for one, would like to see more group practice and less individual practice, more emphasis upon the organization of district health centers and less upon the maintenance of the status quo, I cannot help but recognize that in its aim to remove considerations of cost from the receipt of medical care, the Government has been successful.

Now, as to quality of care. Quality is hard to measure. I don't want to pass judgment on the quality of health services in New Zealand today. I am not a medical man. Speaking as a layman, however, I wish to point out that the whole case for the alleged deterioration in the quality of care rests upon the assumption that we have had a wholesale reorganization in the pattern of medical practice. That assumption has no basis in fact. Our doctors are the same doctors we had in 1940, before the establishment of the medical benefit. Patients still choose their own doctors. Doctors are still free to accept or reject patients. What they do with patients, short of malpractice, is still their own professional concern. Hospital boards still run their own institutions and drug dispensers their own establishments. The only difference from the old arrangement is the source of the money for payment. Why this should make any difference with respect to the quality of service rendered is a complete mystery to me, and, I am sure, to any impartial observer.

It is true that a few doctors have probably taken advantage of the security of income afforded by the fund to go in for overconsultation with patients. That is bad. No one defends it. The Government, I may say, is well aware of this fact and is discussing with the New Zealand branch of the British Medical Association what should be done about these few doctors whose actions may not be in accordance with professional ethics. Where, as in both New Zealand and this country, the number of patients to be seen and the frequency of visits is left strictly to the professional judgment and private conscience of the doctor, it is difficult to prove abuse. Responsibility for proper policing is not wholly the Government's, I may add. The profession, too, has a responsibility.

I want to say a word about the related subject of doctor income. One of the more frequently heard objections to any kind of rational reorganization of health services is the alleged effect upon the doctor's economic rewards. He will make less money, it is said, and because he will make less money, the argument goes on, his incentive to give the best that is in him will be seriously impaired. This comment is not, of course, particularly flattering to the doctor; but assuming it to be true, what are the facts? The fact is that never before in the history of the Dominion has doctor income been so high, never before have the economic rewards for the general practitioner been quite so attractive. The combination of opportunities to render medical service unhampered by patient ability to pay, plus a guaranteed payment per service, has served to put the medical profession in New Zealand nearer the top of the economic pyramid than in any other country. It is the opposite of what some of the critics of health benefits have feared. Doctors have not become poorer. If anything, the medical profession is getting too great a share of the national income .

The other kind of abuse to which it is said our system lends itself may now be mentioned—unreasonable patient demands on a doctor's time and effort. There is some of that, too; not as much, however, as observers 10,000 more miles away think they see. Of course, there are a few neurotics in New Zealand, as there are in this country, too. They may pester the doctor for trivial or imaginary ailments. They are overanxious about a condition very well in hand, from a professional point of view. If they think their present doctor is unsympathetic to their needs as they see them they go to another. They shop around. This is no new problem. We had such people before. You have them now. The problem, however, is minor and is one of proper administration. Regulations have been issued, the effect of which is to spot the hypochondriacs and support the doctor in his refusal to give more service than the situation warrants. Some of these neurotics, I may mention in passing, are really emotionally or mentally unwell and need more, rather than less, medical attention.

You will have gathered from all I have said that the intervention of the Government in the relations of doctor and patient, hospital and patient, and pharmacist and patient is restricted to the economic sphere. The Government pays the bill. It doesn't tell the doctor how to practice medicine or the pharmacist how to compound prescriptions. Of bureaucracy, therefore, if I may use that much-abused word, there is relatively little, and I mention it not because it is an issue in New Zealand, but because I understand it has become one in this country, however imaginary it may be in relation to our system.

Lastly, a word about the bankruptcy which the Journal of the American Medical Association says stares us in the face. We finance our social-security program, as I've said, out of the receipts of a 5-percent tax on income. This source is supplemented by a governmental contribution out of general revenues. This tax, since the beginning of the program, has provided about three-fourths of the receipts of the fund; a registration fee about 3 percent; and the Government contribution the balance. Most of the fund's expenditures are for cash benefits for the aged, widows, orphans, invalids, the sick and unemployed, and for our children's allowance scheme. The health benefits last year represented about 30 percent of the fund's expenditures; and administration, including the cost of tax collections, about 3 percent.

Since the fiscal basis of the social-security program—cash benefits and health benefits together—rests upon taxes, and these are geared to yield enough to pay the benefits, the case for the charge of bankruptcy rests in the last analysis upon the ability of the national economy to pay these taxes. About that, there is not, in my opinion, any question. Unless we go into an economic tailspin which will curtail our whole standard of living what we put aside out of current income will suffice to meet our obligations for cash benefits and health benefits. New Zealand's policy of full employment will insure this.

Only a few months ago, in order to meet expanded pension payments which are now in operation, Parliament strengthened the fiscal base by raising the social security tax from 5 to 7½ percent, effective later this year. We were enabled to do this by reducing our national security or war tax from 7½ to 2½ percent, which means a net saving to taxpayers for both taxes combined of 2½ percent. We spent hundreds of millions of pounds for the war, much of it out of increased taxes; we think it will not be too difficult to find £5,000,000 for health benefits. It is worth at least that much to us in the improved health and well-being of our people.

Our system of health benefits is still young in New Zealand. It has problems and it is experiencing the usual growing pains. It has had to meet special difficulties because of the war. But it stood up under the trying conditions of wartime; and we haven't the slightest doubt that it will gain strength and efficiency in the next few years. And, whatever the Government in office—for the opposition party also subscribes to social security—the system is here to stay.

Senator DONNELL. You are also giving us the original draft as corrected by him, with the corrections shown right there, in pencil or pen, as the case may be, plus the final one. Is that right?

Mr. FALK. Yes, sir.

Senator DONNELL. Very well.

Now, Mr. Cohen, did you go back to see Mr. Sutch yourself?

Mr. COHEN. No, sir.

Senator DONNELL. Who went over to see him when this draft that had been prepared by Mr. Fisher was completed?

Mr. COHEN. I don't know whether Mr. Fisher went to see him or sent it to him. I never did inquire.

Senator DONNELL. You never inquired about that?

Mr. COHEN. No. I made some general statement to Mr. Fisher, to the effect, "See that Dr. Sutch gets this copy." I don't know whether he sent it or took it over or met him later.

Senator DONNELL. Do you have a file in regard to this incident with Mr. Sutch?

Mr. COHEN. No, Senator. Everything that relates to the Sutch incident is in this file that we are submitting to you, as far as I know, Senator.

Senator DONNELL. You don't have any other papers at all relating to this?

Mr. COHEN. No, sir.

Senator DONNELL. I see.

Senator SMITH. Could I ask Mr. Cohen a few questions?

Senator DONNELL. Yes, certainly.

Senator SMITH. Did Dr. Sutch make those corrections himself on that manuscript that you presented to him?

Mr. COHEN. Yes, Senator. That is in his own distinctive handwriting, Senator, and at a number of points, he has deleted or made corrections, which certainly indicate to me that he read it very closely to make it exactly fit his own ideas.

Senator SMITH. I wanted to just bring out that he had done those himself in his own handwriting.

Mr. COHEN. Yes, sir. There are changes on practically every single page.

Senator SMITH. I noticed that in looking it over.

Senator DONNELL. Mr. Chairman, frequent reference has been made to an article in Medical Economics for November 1947. I ask that that article be incorporated at this point in the record, and that if the clerk is able to secure in the record copies of the photographs, that they also be included in the record.

(The clerk subsequently determined that the photographs are not suitable for photoengraving.)

(The documents referred to above are as follows:)

[From Medical Economics, November 1947]

THE MAN BEHIND THE WAGNER BILL

He runs the Social Security Administration's Bureau of Research; he's the Truman administration's oracle on sickness insurance; he wrote the original draft of the Wagner-Murray-Dingell bill; his horoscope puts him high in the Federal medicine firmament; his name, in case you haven't heard, is Isidore Sydney Falk.

(This article, prepared jointly by the editorial staff, stems from more than 2 years of fact-gathering. To collect the data published here for the first time, dozens of sources were interviewed and scores of official records were examined. Much of the research was done by a special investigator for committees of the House of Representatives.)

Of all the 71 witnesses who spoke their piece this year before the health subcommittee of the Senate Committee on Labor and Public Welfare, only one roused the legislator's curiosity enough to win a return engagement in January 1948. Considering the fact that the competition included such intriguing personalities as spokesmen for the Fraternal Order of Eagles, the Methodist Federation for Social Action, and the Communist Party, the Senator's overpowering interest in I. S. Falk may seem surprising. But then, I. S. Falk is a surprising man.

Mention the words "health expert" in Washington's marble corridors and the synonym most likely to bounce back is Dr. Falk. You won't find his name in the AMA directory, though. Nor is he a degree-holder in economics or public health. Like Paul de Kruif, he's an erstwhile bateriologist.

As far as is known, de Kruif's tubthumping for the latest miracle cure has brought him nothing worse than large handfuls of cash and some uncomplimentary fan mail. Falk, is the prime apostle of a new deal in medical care, has been less lucky. His sole reward to date has been three investigations by an ungrateful Congress, plus a fourth scheduled for 1948.

Falk modestly soft-pedals his role as principal author of the Wagner health bill. Until last year, few people knew how important a part he had played. It was only when his immediate boss, the Commissioner of Social Security, was called to a Senate subcommittee hearing that the facts were made public. The testimony went as follows:

"Senator FORREST C. DONNELL. Who is the actual author of the Wagner bill? I mean who actually prepared it?

"Commissioner ARTHUR J. ALTMEYER. It is a product of many minds * * *.

"Senator DONNELL. Was Isidore Falk one of the gentlemen who participated in it?

"Mr. ALTMEYER. Yes, sir. He is Director of our Bureau of Research and Statistics.

"Senator DONNELL. Did he do the bulk of the work in the preparation of the Wagner bill?

"Mr. ALTMEYER. I would not say he did the bulk of the work. He did a major or considerable part of it."

Writing the Wagner bill has been just one item on Falk's jampacked docket. For more than a decade he has worked on Federal health issues with the ambition of an Horatio Alger hero. The commanding position he now occupies in the Social Security Administration[1] attests his success. He has become, in matters of sickness insurance, the Government's man of distinction.

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[1] The Social Security Board was rechristened the Social Security Administration in 1946. The SSA is one of four operating branches of the Federal Security Agency; others are the Public Health Service, the Office of Education, the Office of Special Services.

THE AUTHORITY

Because sickness insurance is so notoriously complex, most anyone who wants to get the low-down on it feels impelled to consult an authority. In the Government that authority is Isidore Falk. When John Q. Public writes to his Congressman for information on national health insurance, his letter often ends up in Falk's basket for reply. When President Truman wants to boost tax-financed medical care for all, Falk is likely as not to compose the message.

When a labor leader wants to stir the folks up about health, his speech is often whipped into shape in Falk's office. When Government agency heads want the latest figures on the cost of social insurance, they beat a path to Falk's door. When Messrs. Wagner, Murray, and Dingell want to fend off harsh words about the health legislation they sponsor, Falk's staff can suggest how to phrase the rebuttal.

Thus, Falk collects the statistics, supervises the research, helps write the legislation, furnishes the supporting data, answers the questions, and does everything but make change. Actually, to get the facts without Falk is a neat trick.

But Falk's crowning glory has yet to come. When—and if—the Wagner health bill is enacted, his name will be a household word among physicians. He, more than anyone else, will shape the character of American medical practice.

The Wagner plan, as presently blueprinted, would come under the aegis of the Federal Security Administrator. But the Administrator is never a man picked for his health-insurance savvy. The current one, Oscar R. Ewing, is a Democratic wheel horse whose familiarity with medicine probably does not exceed that of the average reader of the Home Medical Adviser. He would undoubtedly cast about for Government experts to run the medical part of his show.

Unless something drastic had happened in the meantime, he wouldn't have far to look. Isidore Falk would be standing there—the administration's top health expert—stalwart and ready to assist.

VOICES FROM OFF STAGE

Falk's success has been achieved in spite of some recalcitrant subordinates in the Bureau of Research and Statistics. For reasons of their own, they have said a number of very unkind things about him.

When Margaret L. Plumley resigned from Falk's staff in 1944, she was plain unpleasant about it. She cited these reasons for her departure: "Demands for superficial jobs to be done in a hurry * * * work outlined as of primary importance and great urgency, dropped without explanation after days under pressure * * * always a crisis but never a plan." Concluded Miss Plumley: "Our ideas of what constitute an honest study * * * are too divergent for me to continue working in the bureau." Falk was deeply offended.

One of the last of the M. D.'s to work for Falk, Dr. Ruth E. Stocking, resigned in 1945. She, also, cut her boss to the quick by making a to-do about her "growing sense of distrust for much of the work we do."

Falk was perhaps hurt most when a former employee took occasion to snipe at him by citing this alleged example of the statistical methods used by the bureau:

"Take two persons, both ill at the time of the survey. When questioned as to the duration of their illness, one replies that she has been ill with a chronic ailment for the past year. This gives the Bureau a figure of 365 days' illness. The other person reports a 3-day illness due to a slight cold. These figures are then added, making a total of 368 days' illness for two persons, or two persons ill for a period of 184 days each."

Falk is credited by most of his associates with being clever, hard working, a good writer, and an impressive speaker. Some grumble a bit about what they call "his megalomania and his iron-fisted rule of the people under him," but they have to admit that the personnel turn-over among his staff has never exceeded 95 percent in any one year.

In appearance, Falk is tall and a bit gaunt. Those who don't like him add the word "satanic," but it is only because of the curious curling of an unruly lock of hair above each temple. Under pressure, he smokes somewhat too much and tends to color up boyishly around the ears.

THE FINGER POINTS

The thing that most upsets Falk's enemies is the influence he has been able to exert in the Federal Government. They rubbed their hands in glee, therefore, when he ran afoul of the Subcommittee on Publicity and Propaganda of the House Committee on Expenditures in the Executive Departments.

Over the years, Falk has done his best to create a nice, balmy climate of opinion for Federal medicine. But last summer the above subcommittee, headed by Representative Forest A. Harness, objected. Falk's bureau was one of six agencies reported to the Department of Justice for "using Government funds in an improper manner for propaganda activities supporting compulsory national health insurance."

The talents of Falk and his staff, said the congressional investigators, "were devoted freely from time to time in the preparation of pamphlets and propaganda literature for the CIO, the AFL, and the Physicians Forum. Much of this material * * * supported what certain witnesses refer to as socialized medicine in every approach and dismissed contemptuously all arguments controverting the fixed position of the Social Security Board."

RICH MIXTURE

The fact is, Falk has plumped openly for the Wagner bill in a number of speeches. Some sample audiences: The Virginia Conference on Social Work, the Pennsylvania Association of Dental Surgeons, the Massachusetts Conference on Social Work, the Physicians Forum, the International Labor Organization.

He has turned out a steady stream of articles on health insurance. As much as 10 years ago he wrote an article for the American Journal of Nursing, in which he "stated as objectively and with as much detachment as possible" the following:

"There has been a steady trend from voluntary to compulsory systems * * *. No country which has ever embarked on compulsory insurance has ever given it up * * *. It has always been financially sound * * *. It stabilizes and increases the income of practitioners * * * assures service to the insured."

Falk's bureau also issues such material as "fact sheets" on health insurance. Arguments in some of these sheets are a bit colored, but only to stimulate reader interest. And in no sheet examined do the arguments for Federal medicine number more than 41. An example:

"Voluntary medical care insurance is excessively costly * * *. It does not go far enough * * *. Most of the plans are grossly inadequate in the services they provide * * *. Only a compulsory program can assume complete coverage * * *. Could a [compulsory] program permit free choice of doctor? Yes. Would it destroy personal relationships between physicians and patients? No. Is this an appropriate time for expanding the social insurance program to cover medical costs? Yes. With full employment and high earnings, workers are in the best possible position to insure against future contingencies."

REMOTE CONTROL

The public educational work that Falk can't fit into his own daily schedule he passes on to his staff. The House subcommittee on propaganda had an uncomplimentary word to say about this, too:

"Under date of May 14, 1947, Mr. Isidore Falk * * * sent a memorandum to the Acting Commissioner for Social Security urging that one Jacob Fisher, a member of Mr. Falk's staff, be sent to New Zealand at Government expense to study compulsory health insurance programs and activities in that Nation. We find that this same Jacob Fisher has been documented by the House Committee on Un-American Activities for almost uninterrupted association, since 1939, with various Communist-front and fellow-traveler organizations in the United States.'

New Zealand also figured in a job that Falk was alleged to have entrusted to Wilbur J. Cohen, his second in command. Congressional investigators claimed Falk had been beating the bushes for someone to rebut AMA evidence that state medicine in New Zealand was less than a howling success. Cohen was said to have found such a man in the person of W. B. Sutch, an economist formerly with the New Zealand Ministry of Finance. Cohen and Fisher were then described as writing the script for him. In the words of Cohen's subsequent report:

"When I showed the AMA statements to Dr. Sutch he was very indignant and said he would be willing to send a statement saying that they were false. He agreed to make such a statement *providing that we would make a first draft of what it was we wanted to say* [italics not in original] * * *."

The first draft devised by Cohen and Fisher was scored by enemies of the bureau as "a masterpiece of indignation by proxy."

"During my present stay in the United States," it began, "I have been struck by the character of some of the unwarranted criticism leveled against the New Zealand health benefit program, viz., (1) that it is socialized medicine; (2) that it has resulted in deterioration in the quality of medical care * * *."

For some reason the Sutch statement was not used as planned Nor was it included in the hearings on the Wagner bill earlier this year.

Another maneuver for which Falk is charged with having called the signals was executed in California. SSA files reveal, according to one investigator, that "Falk personally directed, by remote control from Washington, an intensive campaign to enact the compulsory health insurance bill in California 2 years ago."

Falk's representative on that field trip was Margaret C. Klem. Before her jaunt was completed, it allegedly brought protests not only from outsiders but also from SSA personnel. One of Falk's aides is said to have addressed a complaint on that occasion to Barkev S. Sanders, of the bureau's staff, which read, in part:

"You tried to explain to me, when I talked to you about the California trip and its significance, that Miss Klem was not going to California in an official capacity. You explained that Miss Klem would say little, hear much, and later report to us. You will recall that I questioned the appropriateness of this method of obtaining information, but that you made it clear Mr. Falk had made all the arrangements."

The complaint then listed some of Miss Klem's activities while on the west coast. They included the giving of advice about people—e. g., Nathan Sinai—who might serve as good witnesses for the compulsory health insurance cause. It concluded:

WORD TO THE WISE

"As individuals, we are free to express ourselves on problems of social security. But, when, in the minds of our audience, we represent the Social Security Board, we are at once limited in what we are free to say. Our remarks take on a certain authority. The handling of such problems as 'the California situation' has led me to a distrust of our activities."

FRIEND OF LABOR

Still another Falk assistant is Ida C. Merriam. Her main job is liaison with the CIO and the AFL. Falk was smart enough to realize years ago that national sickness insurance abroad had been put over largely by labor groups. The following letter, addressed to the CIO's Mrs. Katherine Ellickson in Washington, shows how competently and closely Miss Merriam has worked at her assigned mission:

JULY 21, 1943.

DEAR KITTY: Here is the revised summary of the Wagner-Murray-Dingell bill. I think it incorporates all the changes we agreed upon.

You will notice that the detailed definitions of fully and currently insured status are typed single space. I would suggest that in the printed version they be set in smaller type than that used for the body of the summary. Proper spacing and typesetting will make the general structure of the eligibility provisions stand out. At the same time the exact requirement will be summarized for anyone who wants to know what it is. * * *

If you want us to check facts and figures in this summary at a later stage, we will be glad to do so.

Sincerely,

IDA C. MERRIAM.

Conditioning the public to his philosophy is a job Falk sometimes delegates to hand-picked subalterns. Not so the business of propelling legislation down the proper channels. That he tackles himself.

He has already tried a number of means to get a Wagner bill through Congress. In 1942, for example, he reasoned that such legislation might whisk through on the coattails of an omnibus social security bill. One-third of the country's physicians were in the armed forces. The rest were bowed down under an unprecedented civilian patient load. It looked like a good moment to get results in the face of a reactionary profession.

Actually, the idea didn't quite click. But there are more where that came from. Their originator has been devising them ever since 1938, when the recommendations of the National Health Conference (largely his work) led to the first Wagner health bill of 1939. Since then, three more Wagner bills have been tossed into the congressional hopper. Each has been carefully revised to silence previous objections. All four bills have borne the I. S. Falk impress.

In view of the many barbs aimed at the Bureau of Research and Statistics, some people profess surprise that its director has not long since come a cropper. These people tend to overlook two things that, more than anything else, keep Falk up there:

1. His backing by the right people. Falk's supporters are few numerically, but they're important. They include the SSA chief, Arthur Altmeyer, and two former FSA administrators, Paul McNutt and Watson B. Miller.
2. His penchant for working unassumingly in the background. Until he was ordered to the stand last summer, he had never testified for the health bills he had authored.

One thing that may have soured Falk on personal publicity was the unfortunately poor press he received during his early career in bacteriology. The uncouth newspaper notices that appeared at the time were enough to give anyone a yen for the cloistered atmosphere of a Government bureau.

The Falk saga began somewhat like this:

About the time the Curies discovered radium, one Samsin Falk, of Brooklyn, N. Y., discovered that his wife was going to have a baby. The following fall—on September 30, 1899—she did. They called him Isidore Sydney.

MAN IN WHITE

He was a bright youngster, energetic and ambitious. At 16 he worked himself into Yale's Sheffield Scientific School. By the time he was 24 he had his Ph. D. in bacteriology. Between times he did some teaching in the university's department of public health.

He had hopes of staying on the Yale faculty after obtaining his doctorate, but somehow the dean of the medical school did not lend support to the idea. So young Falk moved over to the University of Chicago Medical School, where he became an assistant professor of hygiene and bacteriology.

In 1925 he supplemented this appointment by getting part-time work in the city health department. The next year a new health commissioner, Dr. Arnold H. Kegel, came into office and Falk went out. "The occasion for Doctor Falk's dismissal," said an unfriendly Chicago Tribune on December 23, 1927, "was a paper he had prepared for publication citing statistics purporting to show a reduction of tuberculosis under the former regime. Some of the statistics the commissioner believed to be misinterpreted * * * and he called on Doctor Falk for an accounting. In the clash which followed, Doctor Falk resigned."

PROPHET WITHOUT HONOR

In December 1929, while still on the medical-school faculty, Falk suffered still another lacing in public print. When he broke the news that, after a year of research, he had succeeded in isolating the influenza virus, he was greeted immediately by impolite noises at home and abroad. Two London doctors claimed they had reported similar findings 3 years before. The Journal AMA passed off the Falk findings with a terse "unwarranted."

Falk denies that this episode caused his dismissal from the University of Chicago. He was going to make a change anyway. When he did, he sadly pulled the white sheet over his bacteriology career. He was then 30 years old, a man without a metier, and a long way from the top.

UP THE LADDER

What lifted Falk out of the doldrums was an appointment to the committee on the costs of medical care, a foundation-financed unit that was deep in a million-dollar study of the economics of medical service. Falk was an imaginative chap and liked to pass the time of day with his coworkers. One of them, encouraged recently to do a little reminiscing, said:

"Falk's aim in life crystallized when he came to the CCMC. Being an ambitious young man, he decided then to establish himself as the authority on national health, to become in time the leader of American medicine. He has still to realize his full objective, but his progress toward it has been striking."

By the time the CCMC was ready to prepare its final report, Falk had flashed his innate talent as a word-mechanic. The 633-page tome the committee turned out bears Falk's name as coauthor. The health expert legend was in the making.

WHO'S WHO

When the committee disbanded in 1933, Falk moved into the slot of research associate for the Milbank Memorial Fund. While still drawing Milbank paychecks, he picked up his first taste of Government life: He won an appointment to President Roosevelt's Committee on Economic Security. His job: "Technician in charge of studies of the risks to economic security arising out of ill health." Among his colleagues on that committee (which eventually sponsored the Social Security Act) were his present boss, Arthur Altmeyer, and Edwin E. Witte, listed in Who's Who as "consultant on social insurance—International Labour Office."

By 1935 Falk's reputation had spread even among the folks abroad. In June the Milbank Fund announced: "At the request of the medical director of the League of Nations, Dr. I. S. Falk * * * will be in Geneva this summer to advise the League's health organization in planning certain studies of medical care under various health insurance systems in foreign countries."

Falk returned from his League of Nations mission in August 1936, bubbling with ideas for a sickness-insurance program for the United States. On his arrival he was handed a letter that may well have spurred him to where he is today.

It was from his close friend and mentor, Michael M. Davis, then director of medical services for the Julius Rosenwald Fund. The letter blocked out the strategy Davis felt should be used to put over the Federal medicine campaign in this country: It read:

DEAR FALK: I am sorry that your letter comes too late to enable my reply to catch you before you leave Europe. Your remarks about probable developments in public health and medical care stir me to response.

I don't think that any Federal proposals for health insurance are likely to be made for some time. The people of the United States will not at present (1936) be sufficiently responsive to such a proposal to warrant its initiation.

Within a couple of years from the time the unemployment compensation laws become effective, demand will appear for compensation for unemployment caused by illness. This demand will doubtless lead to both State and Federal action; will bring the doctor into the picture, if only to certify disability caused by illness; will familiarize the American public with the idea of social insurance; and will create more of a foundation than we have ever had for understanding social insurance as applied to the cost of medical care. Proposals for health insurance will then enter the area of practical politics.

The research section of the Social Security Board and other sections of the Public Health Service are of fundamental importance. Bodies of facts are going to be made available by the administrative work of the board and by special studies of the board and of the service which will shape professional and lay opinion.

MICHAEL M. DAVIS.

The idea of using Government research bureaus to "shape professional and lay opinion" may have been a new one to Falk, but he was quick to act on it. As a starter, he began urging the SSB's research bureau to get cracking on an analysis of medical care issues. The bureau responded with alacrity. Louis S. Reed, for example, was given the assignment of preparing a report that would deal with "health insurance and the strategy whereby it might be brought about."

Another SSB researcher took on the job of analyzing "certain aspects of public medicine in the United States."

Said the Bureau: "The vitality of the present controversy over provision of adequate medical care creates the need for an analysis of the problems involved and of the extent to which the principles of social insurance can be applied. The exact character of such future research is still under consideration pending the development of a small, highly qualified staff."

PRIZE PACKAGE

The small, highly qualified staff was soon put together—with Isidore Falk included. Christmas 1936 saw him celebrating his appointment as principal medical economist in the Bureau of Research and Statistics. (The Milbank Memorial Fund and he had parted company after an altercation a short while before.)

From then on, Falk moved rapidly. By April 1937 the assignment dealing with "health insurance and the strategy whereby it might be brought about" was no longer on the docket of Louis S. Reed. It had become project No. 1 on the list of I. S. Falk.

Soon the indefatigable Falk took over the supervision of eight new health studies. Among the topics they covered were sickness statistics, industrial medical services, voluntary health insurance, and State medicine. By 1940 Falk had reached his immediate goal—directorship of the Bureau of Research and Statistics, with a salary of $8,000 (he now gets $10,000).

WHAT'S AHEAD

Today I. S. Falk has raised his sights to a loftier target. He would like to be Research Director for the entire Federal Security Agency. An inkling of what's on his mind may be gleaned from the fact that the FSA controls not only the Social Security Administration but the Public Health Service as well.

In the terms of his personal blueprint, Falk has done a remarkable job, so far, of shaping lay opinion. As for shaping professional opinion, his luck has not been so good.

Will he succeed in his latest push? Or will he be knocked down for his part in influencing health legislation? The answer may be forthcoming at his January grilling by the Senate's Health Subcommittee.

Falk's adversaries at that time will do well not to underestimate him. He's not only an able man but a realist. He understands, and has said before a physicians' forum rally in 1944 that "as practical folk, we even have to be prepared, at times, to rise above principle."

Senator SMITH. Senator Donnell, I am sorry to have to make this statement, but I have a very important engagement I will have to keep. I am going to ask you to take over, and ask Senator Murray to excuse me.

Senator DONNELL. I take it the article I have offered will be submitted in evidence?

Senator SMITH. Yes; and the photographs, too, if we can obtain them.

Senator DONNELL. Mr. Chairman, just a moment, before you leave, this article that has been offered and accepted into evidence in Medical Economics is entitled "The Man Behind the Wagner Bill," and I call particular attention to the fact that in the box on the first page, namely, page 46, appear these three sentences:

> This article prepared jointly by the editorial staff stems from more than 2 years of fact-gathering to collect the data published here for the first time. Dozens of sources were interviewed, and scores of official records were examined. Much of the research was done by a special investigator for the committees of the House of Representatives.

Mr. FALK. Mr. Chairman, I wonder whether in that connection I might be privileged to offer for the record an exchange of communications which I had with the editors of that magazine with respect to that article following upon their first submitting it to me allegedly in advance of its publication.

Senator DONNELL. There is no objection. May we see it?

Mr. FALK. May I read it to you?

Senator DONNELL. Yes, if you will. That is fine.

Mr. FALK. I might say by way of preface that I received a manuscript copy of that article.

Senator DONNELL. Before its publication?

Mr. FALK. As far as I know, before it appeared in print.

Senator DONNELL. Pardon me, Mr. Falk, when did you receive it?

Mr. FALK. I received it in my office on November 10, 1947. It was accompanied by a printed card, which I have in my hand, "Medical Economics, Rutherford, N. J." It reads as follows:

> We believe you may wish to read the attached article before publication. It is scheduled to reach more than 125,000 physicians in our next issue. If you feel that any changes in the text are desirable or if you care to suggest any additions, simply indicate them in the margins. We are about to go to press, so please reply at once by air mail—

And there is a check mark there, "Special delivery," and then there are other notations, "Regular mail, collect telephone, collect telegram," and finally, "Thank you, the Editors."

Senator DONNELL. Is that a printed form?

Mr. FALK. That is a printed form.

Senator DONNELL. On a——

Mr. FALK. On a card.

Senator DONNELL. Very well.

Mr. FALK. My reply to them went forward by telegram, addressed to "The Editors, Medical Economics, Inc., Rutherford, N. J.":

> I have received your unsigned manuscript bearing the title "The Man Behind the Wagner Bill." The card attached to the manuscript says you are about to go to press with it and are inviting comments "at once," by air mail and special delivery. You say that "this article stems from more than 2 years of fact-gathering." You have had access to public records, and you have had other opportunities for accurate and objective research. Nevertheless, your article contains errors, untruths, and misrepresentations, and it is "slanted" in such a way as to give the reader an incorrect and unfair understanding and impression of various facts and events. It is, therefore, impossible to believe that any hurried comments I might send you in the form of marginal notes, as requested, could result in making it a fair article. Your article is false, demonstrably inaccurate, and grossly misleading. I believe that the article as a whole has been prepared so as to be intentionally, unfairly, and unjustifiably harmful to me, and possibly to others. I advise and request that you do not publish such libelous material. Confirmation copy follows air mail special delivery.
>
> I. S. FALK.

That telegram is dated "Typed 2:15 p. m., November 14, 1947."

I received a telegram on November 18, 1947, addressed to me, I. S. Falk, Director, Bureau of Research, Statistics, Social Security Administration:

> Your wire received. We tried to make article fair and accurate. It goes to press tomorrow. If you wish to suggest any changes, please wire them at once. If you wish also to submit your views in a short letter after the article appears, we shall gladly consider publishing it.
>
> W. A. RICHARDSON,
> *Editor, Medical Economics.*
>
> 7:56 a. m., November 18.

I sent them another telegram:

> Typed 4:50 p. m., November 18, 1947, addressed to W. A. Richardson, editor, Medical Economics, Rutherford, N. J. I have your night letter dated yesterday. You previously said that your article stems from more than 2 years of fact-gathering. Yet you did not submit it to me until you were about to go to press with it and now you request changes on the day it goes to press. In order to "make article fair and accurate," I believe it would have to be completely rewritten because it contains errors, untruths, and misrepresentations, and is "slanted." I again request that you do not publish the article.
>
> I. S. FALK.

Senator DONNELL. Have you finished?

Mr. FALK. Yes, sir.

Senator DONNELL. Mr. Cohen, there is one other point I would like to address your attention to for a moment. Do you recall a conference of a labor research group which was held in Washington on December 10 and 11, 1946?

Mr. COHEN. Not specifically by that date, Senator.

Senator DONNELL. Well, I will show you this to refresh your memory. I would like to have it back for purposes of interrogating you on it.

Mr. COHEN. I have it here, Senator.

Senator DONNELL. Now if you will just be kind enough to turn to the inside page on the first sheet, do you see that, marked agenda?

Mr. COHEN. Yes, sir.

Senator DONNELL. Do you remember that conference now as you look at this?

Mr. COHEN. Yes, I do, Senator. I participated in that.

Senator DONNELL. You did participate in it?

Mr. COHEN. Yes, sir.

Senator DONNELL. Now, the union representatives attending that conference are listed on pages, I take it, 3 and 4; I don't see any actual page numbers on it, but it is the third and fourth page. That is correct, is it not?

Mr. COHEN. Yes, Senator.

Senator DONNELL. Do you know whether or not there are approximately 37 representatives of various labor organizations listed on those two pages as being present?

Mr. COHEN. That seems about the correct number.

Senator DONNELL. That includes the AFL, the Telephone Workers, the CIO, and the International Association of Machinists, CIO Maritime Committee, and such representatives as United Automobile Workers, American Newspaper Guild, Marine Shipbuilding Workers of America, Hotel and Restaurant Employees' Alliance, Commercial Telegraphers' Union, Amalgamated Clothing Workers, Cigar Makers International Union, National Maritime Union, and numerous others. That is correct, is it not?

Mr. COHEN. Yes, Senator.

Senator DONNELL. I will offer into the record at this time this list of persons in attendance at this conference of December 1946.

(The list referred to is as follows:)

Union representatives attending labor research conference, December 1946

Name	Title	Union
Frank C. Barnes, Jr	Treasurer	International Brotherhood Pulp, Sulphite, and Paper Mill Workers, AFL.
Melvin Bers	Research analyst	National Federation of Telephone Workers, independent.
H. H. Bookbinder	Assistant director of research.	Amalgamated Clothing Workers, CIO.
Alfred Braunthal	Research director	United Hatters, Cap, and Millinery Workers International Union, AFL.
George W. Brooks	do	International Brotherhood Pulp, Sulphite, and Paper Mill Workers, AFL.
George Brown	do	United Association of Plumbers and Steamfitters, AFL.
Paul H. Connelley	do	United Brotherhood of Carpenters and Joiners, AFL.
William Dameron	Grand lodge representative	International Association of Machinists, independent.
Wilbur Daniels	Research associate	International Ladies' Garment Workers' Union, AFL.
Marie Downey	Research assistant	International Brotherhood of Electrical Workers, AFL.
Katherine Ellickson	Assistant director of research.	CIO.
Diana Farnham	Legislative representative	United Office Professional Workers of America, CIO.
Albert Fischer	Assistant to general secretary.	United Brotherhood of Carpenters and Joiners, AFL.
Eileen Fitzpatrick	Social insurance department	AFL.
William Glazier	Washington representative	International Longshoremen's and Warehousemen's Union, CIO.
Ernest Goodman	Attorney	United Automobile Workers, CIO..
Sylvai B. Gottlieb	Research director	National Federation of Telephone Workers, independent.
Eugenia J. Hollis	Educational director	Laundry Workers International Union, AFL.
Carl Huhndorff	Research director	International Association of Machinists, independent.
Clayton E. Johnson	Director, Unemployment compensation department.	United Automobile Workers, CIO.
Elinor Kahn	Research director	National Maritime Union, CIO.
E. Kassalow	do	Rubber, Cork, Linoleum, and Plastic Workers, CIO.
George Kiebler	Educational and research director.	United Automobile Workers, AFL.
J. H. Korson	Research director	Cigar Makers International Union, AFL.
Aileen Lenk	Research associate	American Federation of Hosiery Workers, CIO.
Seth Levine	Research consultant	CIO Maritime Committee.
A. W. Myrup	Research director	Bakery and Confectionery Workers, AFL.
Esther Petersen	Legislative representative	Amalgamated Clothing Workers, CIO.
Frank B. Powers	Research director	Commercial Telegraphers' Union, AFL.
M. L. Preston	do	International Chemical Workers, AFL.
Chas. E. Sands	International representative	Hotel and Restaurant Employees' Alliance, AFL.
R. Schulman	Research director	Marine Shipbuilding Workers of America, CIO.
Glen Slaughter	AFL research department	AFL.
Anthony Weinlein	Research director	Building Service Employees International Union, AFL.
Jean Weinstein	do	American Newspaper Guild, CIO.
Mabel M. Wier	do	Oil Workers International Union, CIO.
A. L. Zwerdling	Office of the presidnet	United Automobile Workers, CIO.

Senator DONNELL. Now the conference was held on December 10 and 11, 1946, was it not?

Mr. COHEN. Yes, Senator.

Senator DONNELL. And I ask you whether or not on December 11, 1946, at the conference, in the morning, from 9 until 12:30 p. m., Mr. I. S. Falk was the discussion leader?

Mr. COHEN. What was that date?

Senator DONNELL. December 11.

Mr. COHEN. Yes. That is what the agenda shows.

Senator DONNELL. And on December 10 you were the discussion leader?

Mr. COHEN. Yes.

Senator DONNELL. And Mr. Altmeyer, of the Social Security Administration, made the opening statement on December 10. Is that right?

Mr. COHEN. I believe that Mr. Altmeyer was——

Senator DONNELL. I beg your pardon, it is Mr. Falk who made the opening statement. That is correct, is it not?

Mr. COHEN. Yes. Mr. Altmeyer was on the agenda as giving the opening statement, but I believe he was not able to attend.

Senator DONNELL. You are correct. Mr. Falk made the opening statement, and then directed that you take over, and you delivered an address of several pages in length. Now I call your attention to this one paragraph on page 3 and ask you whether or not this statement was made by you to the various persons who were present at that conference:

> Perhaps in the long run the more significant developments are in other than legislative fields. As you know, in November 1945 there was a Presidential message on a national health program. This was the first time in the history of this country that any President had sent up to Congress a comprehensive set of recommendations for a national health program. From that standpoint it was an epic-making event. The full-scale hearings on health insurance by the Senate Education and Labor Committee have given an opportunity to bring to public attention the thinking on this subject, crystallizing the views of different groups and bringing some of the issues out before the public.

Did you make that statement at that time?

Mr. COHEN. That is substantially what I said, Senator. I did not make an address in the sense that I had a prepared paper. I believe these are notes that were taken of the informal remarks that I made.

Senator DONNELL. But that does substantially represent the contents of a portion of your remarks on that occasion?

Mr. COHEN. Yes, sir.

Senator DONNELL. Now with that reference to the President's message, I take it that you refer to the message of November 19, 1945, as shown in Document 380 of the House of Representatives, Seventy-ninth Congress, first session. Is that right?

Mr. COHEN. Yes.

Senator DONNELL. I called that message to Mr. Falk's attention this morning and he informed us of something of the participation that has been accorded by your Department in connection with the preparation of it. I will ask you to state whether or not you remember whether someone in your organization inserted into that message this language:

> The American people are the most insurance-minded people in the world. They will not be frightened off from health insuance because some people had misnamed it "socialized medicine." I repeat: What I am recommending is not socialized medicine.

Mr. COHEN. To the best of my recollection, Senator, that was not put in by us. That was in one of the drafts as prepared by the persons in the White House who had the responsibility for preparing the message.

Senator DONNELL. Were there several drafts submitted by the White House to your office?

Mr. COHEN. Oh, yes, Senator.

Senator DONNELL. Of this particular message?

Mr. COHEN. Oh, yes. I couldn't tell you exactly, but I believe that it probably went through at least five drafts, I would say, and perhaps more.

Senator DONNELL. Now, did the first draft originate at the White House or did it originate in your office?

Mr. COHEN. The first draft originated in the White House.

Senator DONNELL. In the White House?

Mr. COHEN. Yes, sir.

Senator DONNELL. Then it was sent to your office. Is that right—I mean the office of the Social Security Administration?

Mr. COHEN. I don't know whether it was sent to our office or whether we were asked to come over to the White House to read it there. My recollection is the latter.

Senator DONNELL. Now, did you and Mr. Falk both go to the White House to read it over?

Mr. COHEN. Yes, Senator.

Senator DONNELL. With whom were you in conference there?

Mr. COHEN. Just a second.

Senator DONNELL. What is your own recollection, Mr. Cohen?

Mr. COHEN. My own recollection is that we went to the White House.

Senator DONNELL. I gather from the colloquy between you and Mr. Falk that Mr. Falk's recollection differs on that. Is that right, Mr. Falk?

Mr. FALK. Yes, sir.

Senator DONNELL. What is your recollection, Mr. Falk?

Mr. FALK. My recollection is that a draft came from the White House to Mr. Altmeyer and that he made it available to us for review and notation, and so forth, and that then at a later stage we were asked to see one or another draft; I don't remember. I confirm what Mr. Cohen says. There were many drafts of it prepared in the White House and that at a later stage, it is my recollection, we read a draft at the White House.

Senator DONNELL. And each of the many drafts was submitted to you, Mr. Falk, from the White House. Is that correct?

Mr. FALK. No, Senator. Those drafts that were submitted to us—I wouldn't say each of many drafts. There may have been many more than we knew about.

Senator DONNELL. But each of many were submitted to you. Is that correct?

Mr. FALK. Each of a number of drafts was shown to us.

Senator DONNELL. Approximately how many were shown to you?

Mr. FALK. I would confirm what Mr. Cohen said, something like five or six.

Senator DONNELL. Five or six drafts of this proposed message of the President were submitted to you and also to Mr. Cohen. Is that right?

Mr. FALK. I think on each occasion, when we saw any of those drafts, Mr. Cohen and I saw them together.

Senator DONNELL. Very well.

Mr. COHEN. I believe that is correct.

Senator Donnell. Now, if we will just proceed with Mr. Cohen on his recollection. Your recollection is that the first draft was shown to you at the White House. Is that right?

Mr. Cohen. That is my recollection. My recollection is that Mr. Altmeyer, the then Chairman of the Social Security Board, said that he had had a call from the White House, as Mr. Falk said this morning, and that they had requested us to give technical advice in connection with the preparation of the message, and that Mr. Falk and myself should make ourselves available to render any technical assistance that the White House requested in the preparation of a message.

Senator Donnell. All right, now, we will just pursue for a moment your recollection. Each one of you gentlemen is entitled, of course, to his own recollection. Now your recollection is that you and Mr. Falk then went over to the White House and went over this proposed message in first draft with someone. Is that right?

Mr. Cohen. Yes.

Senator Donnell. Who was the someone with whom you went over it?

Mr. Cohen. I am perfectly prepared to say—I don't know whether that——

Senator Donnell. Well, if you will say, please.

Mr. Cohen. I mean I don't know whether it is proper to divulge what occurs at the White House. If you think so, I shall be glad to.

Senator Donnell. I see no reason why you couldn't. There shouldn't be any secrecy about it that I know of.

Mr. Cohen. If you think so. The person who was responsible at that time was Judge Samuel Rosenman, who I believe was the special counsel to the President and who had the responsibility for preparing the draft.

Senator Donnell. Do you know whether Judge Rosenman was a man who had acquired a technical knowledge of the history of compulsory health insurance?

Mr. Cohen. I don't know how much knowledge he acquired, but I was certainly impressed with the amount of knowledge that he had for a man in his position who over the last many years has dealt with so many pieces of legislation. I must say I was rather impressed by the extent of his thinking and knowledge and opinion on the subject.

Senator Donnell. Now did you and Mr. Falk make some suggestions at this conference with respect to the first draft when you conferred with Judge Rosenman?

Mr. Cohen. Yes, sir.

Senator Donnell. Do you remember what those suggestions were, in substance?

Mr. Cohen. Oh, no, Senator. We had, as I say, conferences extending over many hours on many drafts, and I couldn't in my own mind distinguish what we told him at the first meeting or on the first draft with respect to the others. I think Mr. Falk will confirm my recollection that we went there several times, and at each time we spent several hours with the judge discussing problems, discussing language, and the judge making notes, comments and writing material, and so forth.

Senator Donnell. Do you recall whether this observation that—

> The American people will not be frightened off from health insurance because some people had misnamed it "socialized medicine"—

was in the first draft?

Mr. Cohen. I couldn't say it was in the first draft, but my recollection is that that was in a draft submitted to us, whether it was the first or subsequent one.

Senator Donnell. Do you recall who originated that statement that I have quoted?

Mr. Cohen. I couldn't say, Senator.

Senator Donnell. Was it originated by someone other than your department?

Mr. Cohen. That is my recollection.

Senator Donnell. I see. And finally the completed draft was submitted to you gentlemen. Was it after these various preliminary drafts had been considered?

Mr. Cohen. As I say, we went through a number of versions and the final draft was never shown us except what came out finally, because I presume there were changes that were made by other persons.

Senator Donnell. I see. Very well.. And all of your conferences were with Judge Rosenman on the subject of this message?

Mr. Cohen. With Judge Rosenman, and I think there were at one time or another some other persons who came in for very brief periods.

Senator Donnell. Were they experts along the line of compulsory health insurance, if you know?

Mr. Cohen. Well, I wouldn't say they were experts on compulsory health insurance, but they had some knowledge of health matters.

Senator Donnell. Do you remember who they were?

Mr. Cohen. I remember two persons that come to my mind.

Senator Donnell. Who were present?

Mr. Cohen. One person was the President's physician, General Graham, I believe, his name is. He participated in one discussion, and in another Geoffrey May of the Budget Bureau.

Senator Donnell. Was Mr. May formerly in the Social Security Board services?

Mr. Cohen. At one time; yes, sir.

Senator Donnell. Was there anyone else that you discussed it with besides Judge Rosenman and those two gentlemen?

Mr. Cohen. Not in any detail, except that when it was completed we went in to see the President.

Senator Donnell. Now, Mr. Cohen, this conference which was held on December 10 and 11 was regarded as an exceedingly important one because of the fact that it was one in which the opinions of great numbers of persons in many, many labor unions of national importance would at least be possibly influenced. That is correct; is it not? I am not using the term "influence" in any ulterior sense. It was expected that many persons would be enlightened by the discussions at this conference, and, therefore, the conference was considered of great importance. That is correct; is it not?

Mr. Cohen. Yes, Senator; particularly because at this time the 1946 amendments to the Social Security Act had just been enacted. They contained a number of provisions which were important and new, and it was thought that it offered an opportunity to both take inventory of those amendments and to explain what they didn't do and what they did do, and to tell about recent developments in the social-security field, because there had been no conference held of this sort during the wartime period.

Senator DONNELL. Was there any discussion by any of these representatives of the labor unions of the comparative merits of the Wagner-Murray-Dingell approach and the S. 545 bill?

Mr. COHEN. I believe you will find in here some references to both of the bills in a factual way—that is, referring to the numbers of the bill, their titles or their major provisions, as well as other bills of a health character and other social-security provisions, but I don't recollect now in detail what was discussed. The record should show whether there was any discussion.

Senator DONNELL. Mr. Falk, you addressed that conference at 2 o'clock on December 10, 1946, did you not, on page 10 and following?

Mr. FALK. Yes, sir.

Senator DONNELL. On page 12 you pointed out what you considered the proper analysis and contrast between the so-called Wagner-Murray-Dingell bill and Taft bill in this language; did you not:

> I want to take only a minute or two to draw certain contrasts between the two major pieces of legislation—the Wagner-Murray-Dingell bill and the Taft bill. As against the Wagner-Murray-Dingell approach of contributory insurance, the Taft bill approaches the problem of providing medical care through selective public charity. The second contrast I would draw between them is that the Wagner-Murray-Dingell has a national approach, with the use of State and local administrative arrangements for the administration of a system which is basically national. The Taft bill provides a basically Federal-State approach. The primary function of the Federal Government would be to set up a simple framework within which the whole scheme would operate, and otherwise to provide grants-in-aid to the States to implement their State and local systems for medical aid. I appreciate that in selecting two such general characteristics and drawing two such sharp contrasts, I have obviously in part misrepresented both bills.

You made that statement, did you not?

Mr. FALK. I made a statement to that effect. I believe what you have read, Senator, as Mr. Cohen has indicated, is that there may not be verbatim notes; they may be only a summary, but I think that is a correct statement. If I may add, Senator, gratuitously, I think it is a very fair, sound, and accurate statement.

Senator DONNELL. I understand that is your point and you were stating it to these gentlemen at that time, because you considered it to be the distinction between the two measures. Is that right?

Mr. FALK. Yes; that is right.

Senator DONNELL. Mr. Falk, in the budget message of the President for 1949 appear two items to which I respectfully direct your attention. One is an item of $15,000,000 for health program proposed legislation, appearing at page M–25 of the message, and also this language, this sentence above the table—some 2 inches or so above it—with certain printing in between, reading: "Health program provision of a national system of health insurance and improved services and facilities for public health and medical care." Did your office have anything to do with the incorporation of that $15,000,000 item in the President's budget?

Mr. FALK. May I see it?

Senator DONNELL. Yes, sir; and while you are looking at it, I call your attention also to page M–27, an item of $150,000,000 for health insurance trust fund proposed legislation, receipts from pay-roll contributions. I ask you the same question with regard to that item.

Mr. FALK. Yes, Senator, we had something to do with each of those, and I will be very glad to tell you about it.

Senator DONNELL. Well, all right, if you will tell us briefly about it.

Mr. FALK. Officers of the Budget Bureau came to my office on a date which I don't recall and asked us for information about the estimated costs of the Wagner-Murray-Dingell bill if it were enacted. We sat around and talked about it for some time, and I gave them the best information I could, indicating what my guesses would be as to how much money would be involved in administration at the Federal level in the event the bill were enacted within some hypothecated period of time. Similarly, they asked for information as to what the approximate yield of pay-roll taxes would be if such taxes were levied in order to implement certain features of the bill. With the help and assistance of our staff, we gave them the information they had requested, and to the best of my knowledge, they utilized it as they thought best in the development of the estimates which are incorporated in the President's budget message.

Senator DONNELL. Now referring to the message of the President under date of January 7, 1948, in the course of which appears this language:

> I have often and strongly urged that this condition demands a national health program. The heart of the program must be a national system of payment for medical care based on well-tried principles. This great Nation cannot afford to allow its citizens to suffer needlessly from the lack of proper medical care. Our ultimate aim must be a comprehensive insurance system to protect all our people equally against insecurity and ill health.

Did your office have any part, by way of consultation or otherwise, in the preparation of that message?

Mr. FALK. I believe not, Senator.

Senator DONNELL. You have been quite closely associated with Mr. Michael M. Davis?

Mr. FALK. Yes, sir.

Senator DONNELL. He was formerly with the Committee on the Costs of Medical Care. That is correct, is it not?

Mr. FALK. He was a member of the committee.

Senator DONNELL. And he was a member prior to your connection with that committee?

Mr. FALK. Yes, sir; the committee started in 1927, undertaking a 5-year program of investigation. He was a member of the committee and of its executive committee throughout that 5-year period, under the chairmanship of Dr. Ray Lyman Wilbur in the full committee and Dr. Winslow in the executive committee. My connection with it began near the end of 1929.

Senator DONNELL. And continued until 1933?

Mr. FALK. Well, yes, sir; through the very earliest months of 1933.

Senator DONNELL. Now in 1938, January 28, of that year, Mr. Davis was appointed as principal consultant in medical economics in the Division of Health Studies of which you were the head. That is correct, is it not?

Mr. FALK. Well, substantially. I believe the appointment is to the Bureau rather than to the Division.

Senator DONNELL. Now you knew, did you not, Mr. Falk, that Mr. Davis has been very active in connection with the activities of various organizations which have undertaken to formulate public sentiment and to encourage public sentiment in favor of compulsory health insurance?

Mr. Falk. I don't think that was so at that time.

Senator Donnell. I didn't say at that time.

Mr. Falk. I thought you were referring to 1938.

Senator Donnell. I mean you have known it for years, have you not?

Mr. Falk. Recent years.

Senator Donnell. How many years have you known that he has been engaged in this sort of work?

Mr. Falk. Excuse me, just a minute, Senator. I am not sure of the words in your question. I have known that he has been very active as an investigator and as a public educator in this field, in the field of health, hospitals, dispensaries, and related matters; he had been for many years before I knew him. In fact, he was one of the most eminent authorities in this country in the field of hospitals and dispensaries before I had ever met him, and he has been an active investigator and educator in this field.

Senator Donnell. What do you mean by public educator?

Mr. Falk. Well, he has been extremely interested, very greatly interested, for many years in the education of the public in understanding health problems, health opportunities, in understanding the problems of health facilities, their construction and maintenance in the community, their financing, the quality of the services that are rendered, the improvement of the quality, and he has been very greatly interested for many years in trying to persuade people in many walks of life on the importance of collaborative work among professional and nonprofessional people in this field of public interest.

Senator Donnell. And he has been very active in educating the public in favor of compulsory health insurance, has he not?

Mr. Falk. In recent years, I think that is true.

Senator Donnell. Well, over about how many years is that true?

Mr. Falk. Oh, I would guess that is true only in the last few years. I hesitate to be precise about it because I don't know offhand, but I would say since something like 1941 or thereabouts. I would take as a benchmark some date after the publication of one of his recent books; I think the last book he published. I say that because I can recall that at the time he was writing a book the title of which escapes me at the moment. He was by no means at that time in favor of national compulsory health insurance.

Senator Donnell. How long ago was that?

Mr. Falk. I would guess, subject to factual verification, that was about 1940, '41, or '42.

Senator Donnell. And did you have anything to do with convincing Dr. Davis that compulsory health insurance was the appropriate type of treatment?

Mr. Falk. If I did have anything to do with persuading him that national compulsory health insurance was a good thing, I would be very proud of it, but I can't be sure of it.

Senator Donnell. I realize you can't be sure as to the inner processes, but you did argue with him and present your views to him or confer with him very frequently on that subject?

Mr. Falk. I argued this question with him on many occasions and we exchanged our views, and if he was influenced by my views, I presume that is about on par with saying that I was influenced by his views or that we each retained our own views on matters on which we may have differed.

Senator DONNELL. But, at any rate, his view changed from being not sure that he was in favor of compulsory national health insurance to being very sure that he was in favor of it. That is correct, isn't it?

Mr. FALK. Well, I don't know about it being very sure.

Senator DONNELL. Well, you know he is the chairman of the Committee on Research in Medical Economics, which is strongly in favor of it, do you not; strongly in favor of compulsory health insurance?

Mr. FALK. No, sir; I don't know that that organization takes any position or has taken any position.

Senator DONNELL. But you do know, however, that he is chairman of that particular committee, do you not?

Mr. FALK. Yes, I do.

Senator DONNELL. And you know that Dr. Ernst P. Boas and Dr. John P. Peters have served on the editorial board of that committee?

Mr. FALK. I didn't think they had an editorial board. They had an editorial board for a publication, the magazine Medical Care.

Senator DONNELL. That is what I mean. You know that they served on that board, Messrs. Boas and Peters, did you not?

Mr. FALK. I presume so. If their names are on it, I probably have known it, because I have seen the list.

Senator DONNELL. And you knew that they advocate compulsory health insurance, did you not, conducted on the national level?

Mr. FALK. As of the time they were on that editorial board, I doubt very much that Dr. Peters did, and I don't know whether Dr. Boas did.

Senator DONNELL. Very well. You are acquainted with the fact that Dr. Davis has been and, I think, still is the chairman of the executive committee of the Committee for the Nation's Health. Is that true, or do you know?

Mr. FALK. So far as I know, that is correct, Senator.

Senator DONNELL. You know that among the gentlemen who are on that committee, namely, the Committee for the Nation's Health, are, again, Dr. Boas and Dr. Peters, do you not?

Mr. FALK. I presume so. I am not sure. I don't remember who is on that committee, but if you say they are, I have no reason to question that.

Senator DONNELL. Well, I am undertaking to ask you if you didn't know that.

Mr. FALK. I am not sure, no, sir, I can't say that I know it definitely.

Senator DONNELL. You know Dr. Channing Frothingham.

Mr. FALK. I have known him for years.

Senator DONNELL. Do you know whether or not he has been chairman of the Committee for the Nation's Health and also chairman of the Committee of Physicians for Improvement of Medical Care?

Mr. FALK. I think at different times he has held those chairmanships.

Senator DONNELL. And do you know also that Dr. Boas is the chairman or has been the chairman of the Committee of Physicians Forum, Inc.?

Mr. FALK. Yes, sir, I do.

Senator DONNELL. And have you not had frequent contacts with some or all of those gentlemen in which you and they conferred with respect to creation of public sentiment in favor of compulsory health insurance?

Mr. Falk. No, sir, I would not agree with that.

Senator Donnell. You have, however, had frequent conferences with Dr. Davis on the subject of compulsory national health insurance?

Mr. Falk. Yes, sir.

Senator Murray. Could I ask a question there? At the time this subject of medical insurance was being discussed, had any branch of the medical society ever expressed its opinion that if we did have an insurance system, it should be compulsory?

Mr. Falk. On at least two occasions that I can recall offhand, Senator, they did, or some part of the association has expressed that opinion.

Senator Murray. So it was an opinion that was held by many people in the country at one time, that a compulsory-insurance system might be the proper kind of a system that we should have.

Mr. Falk. Oh, yes, sir. As a matter of fact, I don't know whether you want me to go into this, but many years ago, the American Medical Association had a special committee making a study of the matter, and that committee, or subcommittee, I forget which, was quite definitely in favor of compulsory health insurance. I don't remember whether that committee's report or its recommendations or resolutions, whatever they may have been, were formally adopted by the association. I do remember, however, if I may volunteer this, that at the time the final reports of the Committee on the Costs of Medical Care were made public, the so-called minority report No. 1—this is the same committee to which Senator Donnell referred—definitely said that if you had to make a choice between voluntary and compulsory insurance systems, that the compulsory had more in its favor. Now I am not professing to quote it accurately. I know that in one of the pamphlets put out by the Bureau of Medical Economics, the opinion was expressed that if an insurance system is to be effective—I think this is the way in which it was presented, that if an insurance system was to be effective in making the benefits of the system available to the poor, the system had to be compulsory.

Senator Murray. And did that occur prior to the time that Dr. Michael Davis began to talk about medical insurance?

Mr. Falk. Well, the first occasion I referred to, the minority report No. 1 of the Committee on the Costs of Medical Care, that is a report issued in November 1932. The other reference I made is to a publication of the bureau of medical economics of the AMA. I think I have it here, so that I can give you the date. I would guess it was in the early 1930's. It is a document entitled "A Critical Analysis of Sickness Insurance," and it is dated—excuse me, it was later; no, I was right about that. Reprinted from the American Medical Association bulletin April 1934, and also revised in 1938.

Senator Murray. So that was long prior to the time that Dr. Davis began to talk about compulsory insurance.

Mr. Falk. Well, in that period, Senator, I am not sure that I can recall accurately whether Dr. Davis had or had not taken a definite position in any of his public speaking or his writings as between compulsory and voluntary insurance, but I am sure that those two dates that I cite are considerably earlier than the period to which

Senator Donnell's question referred, and the period in which I agreed with the Senator that Dr. Davis had been actively engaged in public educational work with respect to compulsory health insurance, 1932 and 1934.

Senator DONNELL. Mr. Falk, you referred to minority report No. 1. What is that a minority report of?

Mr. FALK. It is a report of a minority group of the Committee on the Costs of Medical Care.

Senator DONNELL. Is that the report that is set forth here in this volume that I hand you, entitled "Medical Care for the American People," under the heading of "minority reports and personal statements," beginning at page 151? Is that the report?

Mr. FALK. Yes, sir; that is the document.

Senator DONNELL. Well, now, I want to call to your attention this fact: While at page 164 of that minority report there appears this language:

> It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience, that is, a compulsory plan under Government control.

over on page 165 it says:

> The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance.

Do you recall that?

Mr. FALK. Yes, sir; I do very well. That is why I said that as between compulsory and voluntary insurance, that minority group said, in effect, that the compulsory form was better or more effective or likely to be more successful, or whatever words they use. May I add this, Senator, that I did not say what I did in the nature of indicating anything in the way of a blanket or unqualified endorsement of compulsory health insurance any more than of voluntary insurance, because that minority report was more condemnatory of voluntary insurance than of compulsory insurance. I only put it in the form of a comparison.

Senator DONNELL. But you note, do you not, Doctor, that this minority report certainly left no inference of being favorable to compulsory health insurance?

Mr. FALK. Nor voluntary insurance.

Senator DONNELL. I understand, but I am talking now about compulsory health insurance. There is no inference, in your opinion, is there, in favor of compulsory health insurance from anything that appears in that report?

Mr. FALK. Quite right, Senator, and as I say, I remember that report. I used to know that report very well, having been present at the meetings at which that report was discussed and at which it was adopted. That group said that, on the basis of experience, if you have to choose between one or the other, then the compulsory insurance is the better choice. And I think that is a very important statement, particularly in light of the fact that in the years that have elapsed since then, the American Medical Association finally came around to endorse voluntary insurance.

Senator DONNELL. Well, now, the language to which you refer is the language that I have read from this report?

Mr. Falk. Yes, sir.

Senator Donnell. (Quoting):

> It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience, that is, a compulsory plan under Government control.

But the same committee, within 12 or 15 lines, or thereabout, thereafter says:

> The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance.

I am quoting correctly, am I not?

Mr. Falk. I believe you are, Senator; yes, sir.

Senator Murray. Well, the American Medical Association has changed its judgment on that now and is in favor of a voluntary method.

Mr. Falk. Yes, sir. They are sponsoring voluntary insurance plans.

Senator Murray. Although they condemned voluntary insurance in this minority report.

Mr. Falk. Yes, sir.

Senator Donnell. Now, Mr. Falk, during your connection with the Committee on the Costs of Medical Care, you had among your assistants in the research staff Miss Margaret C. Klem?

Mr. Falk. Yes, sir. She was with the staff before I was, sir.

Senator Donnell. And she later on became a member of your staff in the Social Security Administration; is that right; and still is?

Mr. Falk. Yes, sir; only after she had been in the Social Security Board in another staff, she eventually came to my Bureau.

Senator Donnell. But she is now in your Bureau?

Mr. Falk. Yes, sir.

Senator Donnell. And Mr. Louis S. Reed, who was on your research staff on the committee on the costs of medical care, is now on the staff of Mr. George St. John Perrott of the subcommittee on medical care and of the committee on adequacy studies. That is correct, is it not?

Mr. Falk. I don't believe so, Senator. I don't recognize either of the latter committees.

Senator Donnell. Do you recognize the United States Public Health Service? Mr. St. John Perrott is in the United States Public Health Service, is he not?

Mr. Falk. Yes, sir; but I didn't understand that you were referring to the Public Health Service.

Senator Donnell. I am referring to two other committees here, but I say you have recognized the United States Public Health Service, naturally, even though you do not recognize these two committees, a committee on adequacy studies and a subcommittee on medical care.

Mr. Falk. I do recognize the committees, but I am saying, Senator, I do not recognize those as committees of the United States Public Health Service. Mr. Reed is an employee of the United States Public Health Service.

Senator Donnell. I am not saying they are not. They are governmental committees, though, are they not?

Mr. Falk. Would you read the names again?

Senator DONNELL. Committee on adequacy studies and the subcommittee on medical care.

Mr. FALK. I don't know the latter. The committee on adequacy study—there is a subcommittee of that name, which is a subcommittee of a Budget Bureau committee, which is a committee on matters of interdepartmental interests. I don't know whether there is any longer a committee of that name.

Senator DONNELL. Did you ever hear of a subcommittee on medical care which was set up as an interdepartmental committee, with Mr. George Saint John Perrott as chairman, Mrs. Martha M. Eliot, Miss Margaret C. Klem, and Mr. M. I. Romer? Did you ever hear of that committee?

Mr. FALK. I may have, but it strikes no responsive note in my memory at the moment, Senator. It doesn't mean anything to me.

Senator DONNELL. Now, doctor, in addition to your advocacy of these various bills for health insurance in the United States, has your Department undertaken to suggest courses of action in international affairs which are in favor of compulsory health insurance elsewhere than in the United States?

Mr. FALK. Senator, the first part of your question referred to advocacy of the bills in the United States. I am not aware of any advocacy of the bills in the United States except through the formal and official channels of the Administration with which I am connected. As to advocacy of health insurance in any other country, the answer is emphatically "No."

Senator DONNELL. In regard to this advocacy of bills, do you remember attending a meeting on March 7, 1946, in the Archives Building Auditorium sponsored by the District chapter of the National Lawyers Guild which was addressed by yourself?

Mr. FALK. Yes, sir; I do.

Senator DONNELL. Was not that an instance in which there was advocacy of a national health program to cover everyone in the Nation?

Mr. FALK. There may have been advocacy of a national health program, but that isn't what I understood your question to deal with. We advocate a national health program and have since 1938, when such a program was submitted at a national health conference held in Washington, D. C., but the advocacy of bills is quite another matter.

Senator DONNELL. Have you not advocated the enactment of the Wagner-Murray-Dingell bill at any time?

Mr. FALK. We have in the sense and through the channels, as I indicated, in the sense that we have reported favorably on those bills in our official communications and the appropriate officers of the Agency, and of the Administration have so testified before committees of the Congress.

Senator DONNELL. And you have frequently expressed yourself to be in favor of those respective bills?

Mr. FALK. On such occasions; yes, sir.

Senator DONNELL. Now, Mr. Falk, I refer particularly in connection with the international situation to recent activities in connection with Japan. Have you had anything to do with a special health mission to Tokyo, with a view to assisting the formulation of a new national health program for Japan?

Mr. **Falk**. Sorry, Senator, but your question doesn't lend itself to a "Yes" or "No" answer, because it contains some things to which I would answer "Yes" and other things which I would have to answer "No" if I were giving you a correct answer.

Senator **Donnell**. At this point, gentlemen of the committee, I offer for the committee in evidence a letter dated September 9, 1947 from Representative Forest A. Harness to the Honorable John Taber, Washington, D. C., the opening paragraph of which reads:

> The subcommittee investigating publicity and propaganda in the executive agencies of which I am chairman learned recently that the Social Security Administration, the United States Public Health Service, and Public Housing Authority have sent a special health mission to Tokyo, with a view to assisting in the formulation of a new national health program for Japan. This mission is operating on a temporary basis as a function of the War Department.

Thereafter follow the subsequent recitals of this letter which I shall not read in full since the letter is offered in evidence, and, therefore, will be before us completely for consideration.

(The letter submitted by Senator Donnell is as follows:)

House of Representatives,
Subcommittee on Publicity and Propaganda
of the Committee of Expenditures in the Executive Departments,
Washington, D. C., September 9, 1947.

Hon. John Taber,
Chairman, Committee on Appropriations,
House of Representatives, Washington, D. C.

Dear Congressman Taber: The subcommittee investigating publicity and propaganda in the executive agencies, of which I am chairman, learned recently that the Social Security Administration, the United States Public Health Service, and the Public Housing Authority have sent a special health mission to Tokyo with a view to assisting in the formulation of a new national health program for Japan. This mission is operating on a temporary basis as a function of the War Department.

In a letter addressed to Mr. Watson B. Miller, Administrator of the Federal Security Agency, under date of August 6, 1947, the Secretary of War stated the objectives of the mission were "to consult with the Public Health and Welfare and with the Japanese Committee on Social Insurance and Japanese Council on Medical Care for the purpose of drafting a national health bill which will incorporate a unified national health program with a national medical-care program. This bill must be available to present to the Diet not later than October 1, 1947."

I deem it proper to bring this matter to your attention because it appears to me to involve a question of legislative policy for the consideration of the Appropriations Committee. All members of this mission are permanent, full-time employees of the Federal Government and are well known in the United States for their persistent agitation for a national system of socialized medicine to be achieved through a program of compulsory health insurance. The members of the mission are: Joseph W. Mountin, associate chief, Bureau of State Services, United States Public Health Service; Burnet M. Davis, surgeon, United States Public Health Service; Barkev S. Sanders, chief, Health Studies Division, Bureau of Research and Statistics, Social Security Administration; and Frances A. Staten, assistant regional director for management, Federal Public Housing Authority.

This mission departed for Tokyo on August 28, 1947. We are informed that at a later date the mission will be expanded to include Mr. Arthur J. Altmeyer, Commissioner of the Social Security Administration; Mr. Wilbur Cohen, Assistant Director of the Bureau of Research and Statistics; and possibly Mr. I. S. Falk, Director of the Bureau of Research and Statistics.

In reply to allegations by the War Department that protests against this mission have been based on lack of information, please be advised that my statements are founded upon what purports to be the complete file of the War Department in this matter. These files indicate definitely that the plans for the mission were originated by key agitators for socialized medicine on the Federal pay roll in

Washington and their collaborators on the Federal pay roll in Tokyo; that very close liaison was maintained among the two groups, and that the basic purpose of the mission is the establishment of socialized medicine in Japan.

In preparation for the mission, a civilian employee, Mr. Stanchfield, was sent to Tokyo to make a preliminary survey of social security and health needs. Thereafter Mr. Stanchfield proposed the mission to Arthur J. Altmeyer, Commissioner of the Social Security Administration, and on March 5, 1947, Mr. Altmeyer in a letter to the War Department designated the personnel to be included in the mission, and suggested Mr. William H. Wandel, Chief of the Program Division, Bureau of Unemployment Security, as a member, and suggested that Mr. Wandel precede the mission to Japan by about 3 months and that he should remain 3 months after the mission had completed its visit to Japan to finish up any necessary details, and he further suggested that while in Japan on the mission, Mr. Wandel serve as Chief, Social Insurance Division, Public Health and Welfare Section of the Supreme Command for the Allied Powers (SCAP).

It is apparent from the letter herein referred to from Mr. Altmeyer to the War Department that the personnel of the mission and the planning of its program was dictated and originated in and from the Social Security Administration in Washington. There is nothing in the entire record before us to indicate or suggest that the need for the mission was suggested originally either by General MacArthur or any responsible Japanese source. To the contrary, our records contain a letter, under date of June 14, 1947, from William H. Wandel, Chief of the Social Security Division, Public Health and Welfare Section of SCAP, to I. S. Falk in Washington, outlining the real purposes of the proposed mission. In this letter Mr. Wandel said in part:

"We now think that our need is for someone who is primarily not so much an economic analyst as one versed in health insurance. Health insurance is the major field of social security in Japan. * * * Permanent revision requires amalgamating national health insurance with health insurance, on a compulsory basis."

In a letter from William H. Wandel from Tokyo to I. S. Falk of the Federal Security Agency, Mr. Wandel exposed the fact that there were conflicts of interests as to the purposes to be accomplished when he stated: "I find the work here very interesting and engrossing. One is reminded forcibly of the apparently universal character of the conflict of established interests, but nevertheless there are real possibilities for accomplishment. I am glad I came out."

It has also come to the attention of our committee that Dr. B. M. Davis, one of the members of the Tokyo mission returned only recently from London, where he was attached to the British Ministry of Health, to assist in the national program for socialized medicine in England. He is the son of Mr. Michael M. Davis, chairman of the executive committee of the Committee for the Nation's Health, the foremost lay organization agitating for socialized medicine in the United States, as embodied in the Wagner-Murray-Dingell bill. The Committee for the Nation's Health, as our report reports have delineated, is the principal national organization in the United States engaged in distributing the propaganda of the Social Security Administration supporting socialized medicine.

I feel strongly that the question fairly arises as to when these gentlemen work for the people of the United States who pay them? Our committee has already traced out their operations in New Zealand, in England, in Latin America, and finally in Japan. Personally, I feel that if the American taxpayers are supporting a world-wide movement for socialized medicine, then the people are entitled to know it and to know how much such international activities are costing them.

We have been investigating this situation for 6 weeks. Our conclusions to date are as follows:

1. That the health mission to Japan is composed entirely and exclusively of men long identified in the public record as advocates and proponents of socialized medicine not only in the United States but throughout the world.
2. That the real purpose of this mission is to lay the ground work for a system of socialized medicine in Japan.
3. That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington, and nowhere else.
4. That the nominal request for the mission was engineered through the general headquarters of the supreme commander in Tokyo by Federal employees sent from Washington for that particular purpose.
5. That Gen. Douglas MacArthur does not favor, and does not approve, any plan to establish compulsory socialized medicine in Japan.

6. That the dispatch of this mission to Tokyo for the purpose indicated in Mr. Wandel's letter to Mr. Falk under date of June 14, 1947, is a gross misuse of public funds.

7. That the real purpose of the mission is not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine.

8. That although the questions here involved are of a health and medical nature, the Surgeon General of the United States Army was not consulted in reference to the problems involved.

I deem it inappropriate for Federal employees, at the expense of the American taxpayer, to travel throughout the world preparing or assisting in the preparation of legislation to be adopted by foreign countries when similar legislation, long pending, has not been approved by the Congress of the United States.

We are continuing our investigation of the origins and real purposes of the Tokyo health mission. Meanwhile we believe that your committee would want to have these facts before it when the next appropriation bill comes up for the Public Health Service and the Social Security Board.

I am most anxious to cooperate with your committee, and will be happy at any time to make available to you or your staff the documents assembled by the staff of my committee in regard to this matter.

Sincerely yours,

FOREST A. HARNESS.

Senator DONNELL. Are the contents of the opening paragraph as I have read them correct, and if not, in what respects are they incorrect?

Mr. FALK. Excuse me, Senator. I am afraid I wasn't following.

Senator DONNELL. Do you have a copy of the letter?

Mr. FALK. Which letter is this?

Senator DONNELL. September 9, 1947, from Mr. Harness to the Honorable John Taber, chairman, Committee on Appropriations.

Mr. FALK. I have that letter.

Senator DONNELL. If you will address yourself to the first paragraph of that letter, will you tell us if that is a correct statement of the fact, and if not, in what respect is it inaccurate or incorrect?

Mr. FALK. It is substantially accurate except on one point. It says that the Social Security Administration, Public Health Service, and Public Housing Authority have sent a special mission to Tokyo with a view to assisting in the formation of a new national health program for Japan. Let me amend my statement and say it is inaccurate in two respects. That mission was not sent by the Social Security Administration, the Public Health Service, and the Public Housing Authority. It was sent by the War Department. In the second respect, it says: "With a view to assisting in the formulation of a new national health program for Japan."

So far as I know the facts concerning this subject, that mission was sent to Japan to assist General MacArthur and his staff in their work on their problems in working for the rehabilitation of Japan.

Senator DONNELL. Mr. Falk, who was it, if you know, that originated the idea of sending the mission to Japan?

Mr. FALK. Senator, I have no first-hand knowledge of that except on one point, but I will tell you what I know about it.

Senator DONNELL. Very well.

Mr. FALK. I will tell you what my personal knowledge of it is. Then, if you like, I will give you all that I understand about it. There are others better informed on this matter, that know about it.

Senator DONNELL. Very well.

Mr. FALK. My personal knowledge of the origin or initiation of it was when one of General MacArthur's officials came to see me and asked whether I could be persuaded to come to Japan to work on their staff. We had one, two, or three discussions, and I informed him that I was not available for that work. He asked other persons to consider an assignment—an invitation—to join General MacArthur's staff. He had considerable difficulty in recruiting the staff which he had been sent to the United States to recruit for General MacArthur.

On failing in that, he asked the Commissioner of Social Security to have what is referred to as a mission sent to Japan to assist them in their work in connection with the study and reorganization of the social-security program in Japan.

I believe that answers your question, Senator, as to on whose initiation or on whose motion it originated.

Senator Donnell. Yes.

Mr. Falk. It is a matter of public record that General MacArthur himself has said that it originated with him and his staff in Tokyo.

Furthermore, if this committee is interested in the details of this Japanese mission, and if it wishes to see what misrepresentations, falsehoods, and untruths have been stated about it, I would suggest that it ask Mr. Harness to furnish this committee all of the information at his disposal, since it is my understanding that he himself now knows and his committee now knows that this mission to Japan originated with General MacArthur, and the committee has been so informed authoritatively.

Senator Donnell. Did the mission go to Japan?

Mr. Falk. A mission went to Japan; yes, sir.

Senator Donnell. A mission did go?

Mr. Falk. Yes, sir.

Senator Donnell. Who comprised that mission?

Mr. Falk. Mr. Altmeyer was the chairman of the committee, or the head of it—I do not remember his precise title, but he did not go. The officers who were sent included Mr. Wandel, an officer of the Social Security Administration, who was released from his position in the Social Security Administration in order to serve on General MacArthur's staff.

Senator Donnell. Was he not already there before the mission went?

Mr. Falk. Senator, I am speaking from second-hand information here because I have had very little personal knowledge of or contact with the details of this mission, but it is my understanding that his going to Japan was part of the mission's undertaking.

In addition there were four other officers who went: Dr. Joseph W. Mountin, Associate Chief, Bureau of State Services, United States Public Health Service; Dr. Burnet M. Davis, surgeon, United States Public Health Service; Mr. Barkev S. Sanders, Chief, Health and Disability Studies Division, Bureau of Research and Statistics, Social Security Administration; and Mr. Francis A. Staten, Assistant Regional Director for Management, Federal Public Housing Authority—I know he had formerly been an officer in a housing agency—I forget which one it is, but I think perhaps it is the Federal Public Housing Agency, as stated in Mr. Harness' letter.

Senator Donnell. Bearing on the subject matter of your testimony, I think it proper to offer into the record this release from the War Department under date of August 27, 1947, which reads as follows:

(The document above referred to is as follows:)

Immediate Release

War Department,
Public Information Division,
Press Section,
August 27, 1947.

SOCIAL SECURITY MISSION DEPARTS FOR TOKYO THURSDAY

The War Department has announced the Thursday departure of a mission to Japan being sent at the request of Gen. Douglas MacArthur, Supreme Commander for the Allied Powers, to evaluate and to make recommendations regarding measures to achieve a sound social-security system for Japan.

Four advance members of the mission departing today by air are prominent health and welfare officials who, it is expected will be joined at a later date by two other members in addition to Mr. Arthur J. Altmeyer, Commissioner, Social Security Administration. They are Dr. Joseph W. Mountin and Mr. Burnet M. Davis of the United States Public Health Service; Mr. Barkev S. Sanders, Social Security Administration, and Mr. Francis A. Staten, Public Housing Authority.

General MacArthur, last April, requested that Mr. Altmeyer be invited to head a six-man mission that would visit Japan in September for a period of 30 to 90 days. The mission will consult with public Health and Welfare Section, SCAP, and will offer technical guidance to the Japanese Committee on Social Insurance and the Japanese Council on Medical Care which are presently engaged in drafting a coordinated national health bill.

The Japanese workmen's compensation and seamen's insurance laws have been recently reformed, a child-welfare law is now pending, and a national health insurance law passed in 1926 and extended in 1942, covers approximately 42,000,000 Japanese. In March 1947, the Japanese Diet passed a resolution recommending the extension of the national health insurance law.

Distribution: Aa, Af, B, Da, Dd, Dm, N.

7 p. m.

Senator Donnell. The Mr. Burnet M. Davis referred to in that press release is the son of Michael Davis; is that correct?

Mr. Falk. That is right.

Senator Donnell. All right.

Mr. Falk. What is the date of that release, Senator?

Senator Donnell. August 27, 1947.

Mr. Falk. Were you also—I hope I am not interrupting your chain of thought—were you also going to read into the record—and if you had not expected to, may I ask that you do so—the release from General MacArthur dated August 31, 1947?

Senator Donnell. If I have it, I will be glad to read it into the record. I am not sure whether I have it here or not. Yes, here it is. Do you want me to read it into the record, or do you want to read it into the record? Whichever you wish.

Mr. Falk. That should also go into the record, I think, Senator, in view of the public discussions which were precipitated. In view of the fact that Mrs. Shearon has remarked in one of her letters that it was first called to the attention of the Harness committee by her, I think it should be made of record that General MacArthur himself, in a direct release from Tokyo, made the facts of public record. That is the release of August 31 to which I refer.

Senator Donnell. Will you read it into the record, Mr. Falk?

Mr. Falk. Yes, I shall be very glad to read it into the record, Senator.

Senator Donnell. All right.

Mr. FALK. This is entitled "War Department Classified Message Center, Incoming, Clear Message, Priority, From GHQ, SCAP." SCAP, I believe, stands for the Supreme Commander of the Allied Powers, Tokyo. It is signed "MacArthur." It is addressed to the War Department, and there are a number of letters and numbers appearing on the document, "War for WDSCA, Z 20007," which is dated the 31st of August 1947, "Reur WAR 85264." It says:

> There is no slightest concept at this headquarters of any socialization of medicine in Japan. The purpose of the mission from the United States is to advise with reference to the coordination and application of social-security measures which have been in practice in Japan for many years. In the aftermath of the war and the economic stringencies resulting therefrom, the Japanese Government has found manifold difficulties in the implementation of its old health-security laws. It appealed to this headquarters for advice and assistance in consolidation and simplification of existing codes in view of the general revision in governmental structure now taking place.
>
> As the appropriate section of SCAP did not possess the expert ability called for, the United States Government's corresponding services were requested to lend competent personnel for a short period of time to consult with and advise in the premises. The individuals selected for this purpose are personally unknown to this headquarters but as responsible public officials of the United States Government must be presumed to be qualified. No socialization of medicine is at issue, and nothing of propaganda is involved. The Japanese Government requested the advice and will be entirely free to accept it or not as it may wish. Its scope is not designed to initiate any concepts beyond present Japanese laws and will be limited merely to pass upon the adaptability, workability, and practicability of those now existent.
>
> Nothing new is planned beyond making old practices work. So far as this headquarters knows there has been no slightest effort or thought on the part of the United States Government services to inject themselves into the matter nor to impose any preconceived concepts or controversial issues such as the socialization of medicine on Japan, and their actions in making experts temporarily available represent nothing but healthy assistance in response to a normal request from a fellow govermental agency.
>
> I suggest that the above facts be furnished those who protest this mission. I am sure the protests are caused by lack of accurate information in the matter.

Senator MURRAY. Mr. Chairman, at this point I think it would be proper to have read into the record the release by Dr. Marjorie Shearon, which is supposed to have precipitated all this controversy with reference to the mission to Tokyo.

The release is dated August 20, 1947, and reads as follows:

> FLASH
>
> AUGUST 20, 1947.
>
> *Confidential, for subscribers only.*—Not to be shown to anyone else. Not to be released to the press. This story will not "break" for several days. The leads were mine, but the follow-up investigation has been done by the Harness subcommittee, and I do not wish to steal their thunder. I am sending this in the hope that some of you may be in position to act before August 28.
>
> *Social security mission to Japan.*—Over 2 weeks ago I gave to Frank T. Bow, of the Harness subcommittee, the information which has enabled him to expose the grandiose plans of Falk, Altmeyer, Cohen, and Miss Mulliner (Senator Wagner's protege) to socialize medicine in Japan, and to foist a WMD bill on the defenseless Japanese. It is a brazen scheme which has been in the making since the end of the last year. The War Department has been sucked in. Falk plans; Altmeyer gives official sanction and accepts leadership of the mission to Japan; Cohen and Miss Mulliner execute the plans; the public pays the freight.
>
> The advance guard is already in Japan; the mission is to leave Washington on or before August 28. Altmeyer, still in Geneva, is to follow later; selected or mentioned as possible additions to the mission are: Perrott, Louis Reed, Miss Klem, Falk's former assistant, Francis A. Staten, Bishop, Berlin refugee from the Berlin social insurance fund, formerly on Sanders' staff, and several others,

all responsive to Falk. All told, 9 of the 44 persons listed in my House of Falk diagram have been selected or mentioned for the mission. Dr. Mountin, Burnet M. Davis, and Barkev Sanders are scheduled to leave by August 28. They are to prepare, or take with them a prepared, national compulsory "health" insurance bill to be presented to the Japanese Diet by October 1. There has been opposition to the program in Japan, but what can a vanquished nation do to protect itself against a power-crazed group of bureaucrats from Washington? What were the Germans able to do when Altmeyer sent Merrill Murray from the Social Security Administration Bureau of Old-Age and Survivors Insurance to Germany under War Department auspices?

If you wish to protest, do so now. Tomorrow may be too late. Kenneth C. Royall, Washington, D. C., is Secretary of War. General MacArthur in Tokio is supreme commander for allied powers (SCAP for short). William H. Wandel, chief of public health and welfare section, social security division, SCAP, in Tokio, is the man in communication with the War Department in Washington and with Falk. Wandel was selected for the post by Altmeyer. Remember the time is very short. Your Senators and Representatives may be interested.

New Federal Security Administrator appointed.—On August 19, Watson B. Miller was removed as head of Federal Security Agency and made Commissioner of Immigration. The new Administrator of Federal Security Agency is 48-year-old Oscar Ross Ewing, lawyer, member of the New York City firm of Hughes, Hubbard & Ewing. From August 1940 to May 1942 he was assistant chairman of the Democratic National Committee. He was then made vice chairman of the Democratic National Committee. There does not appear to be anything in his background to indicate any familiarty with social security, health, education, or medical programs. He would appear to be a good political appointee for the head of Federal Security Agency, which, as a dispenser of public charity and distributor of Federal largesse makes the old WPA look like a small-town ladies' aid society.

It is signed by "Marjorie Shearon, Ph. D., legislative consultant."

This, as I say, is dated August 20, 1947. At that time, my understanding is that Dr. Shearon was working here around the Senate on this legislation, and either represented the National Republican Committee or was working for some of the Members of the Senate.

I understand that now she is a registered lobbyist.

Mr. Falk. Mr. Chairman, may I add something at this point?

Senator Donnell. Yes. I want to ask you a question, too, but go ahead.

Mr. Falk. As I said earlier, I know very little about this Japanese mission from any first-hand knowledge or contact, because I had very little to do with it. Beyond having been asked whether I personally might take an assignment for 2 years in Japan, which I respectfully declined, I had very little to do with it except to participate at a later stage, at the request of Mr. Altmeyer, in making a member of the Bureau staff available. Beyond that I had very little to do with it.

But the facts which are of record are very plain. Our distinguished commander in Tokyo requested help from the United States Government, here on the continent, to assist him in staffing in order to meet problems with which he was confronted in the social-security field. He sent a member of his staff to the United States with authority to do the recruiting. That staff member had difficulty in getting people to go, for various reasons: term, conditions, separation from their families, and so on. In many cases I do not know what the reasons were, but I do know that he had difficulty.

As I understand it, on checking with General MacArthur's headquarters, he was authorized to propose to Mr. Altmeyer the formation of a mission, a short-term assignment. On that request, through the War Department, the Federal Security Agency met that request, as it properly should, to give assistance to the general in Tokyo. That assistance was given, and a group of officers of the United States Government were temporarily released from their duties here in the United States and made available to go to Tokyo to assist General MacArthur.

It seems to me there is something extraordinarily bad in a situation of this kind under which, when a branch or when branches of the United States Government undertake to give assistance requested of them by General MacArthur in Tokyo, that a furore should have been created, public discussions based upon misinformation precipitated, difficulties thrown in the way of the work of members of the United States Government, officers of the United States Government working here, and when they undertook to do work which was thrust upon them, to have to apologize or explain away misinformation which, from the document which Senator Murray read, apparently arose from the fact that Mrs. Shearon learned that this mission was to go to Tokyo to assist General MacArthur, reading into it that it initiated here—which it did not—that its purpose was to socialize medicine in Japan.

Japan has had health insurance since 1922, and a very large portion of the Japanese population has for years been covered under their own health insurance plan.

Further, that officers of the United States Government should have had these dire charges thrown at them; that a committee of the House should have, by public releases and otherwise, not only interfered but undertook to stop this mission from going to Japan in compliance with General MacArthur's request, and otherwise attempted to hamper its activities.

I think this is something that deserves very serious criticism, and if the committee wishes to have further details—much of which, as I said, comes to me at second-hand, but it is available in document form from persons who can speake authoritatively—I shall be very glad to see that they are made available, including not only the releases which have already been read but communications between the War Department and General MacArthur, and from General MacArthur, which have been made available to us.

Again I would like to refer to the fact that I am informed that Mr. Harness' committee has had direct testimony and information furnished them to assure them that they had been misinformed in the first place in connection with these untruths and misinformation in the attacks they made on that mission.

Senator MURRAY. Do you mean to infer that they have suppressed this information?

Mr. FALK. I only mean to say this, Senator. I am informed that at a meeting of Mr. Harness' committee a very high-ranking officer of the United States Army testified that he had personally been assured by General MacArthur and by one of his colonels that they were responsible for that mission which was invited to go to Japan. I believe there is other information available to Mr. Harness and his committee to the same effect. But I notice this, there has been no statement made, no public statement—none has come to my attention, at any rate—from Mr. Harness or his committee stating these facts, indicating for the purpose of the record that they had been misinformed and that the charges which they alleged against the mission—Mr. Altmeyer, Mr.

Cohen, myself, and others—were incorrect or were based upon misinformation.

On the contrary, there has recently been published in the Reader's Digest, for the month of December 1947, if I remember correctly, an article by Mr. Harness in which he again repeats the statement that this mission and the idea for it originated in my bureau.

I believe that article was later reprinted in the Congressional Record, if I am not mistaken, and I shall not take the time to check the record at the moment. Further, if I remember correctly, he repeated those charges in an address which he recently made before the National Physicians Committee, and that, too, was recently printed in the Congressional Record, and I believe that some of these items which I mentioned last that occurred were made public subsequent to the time when Mr. Harness' committee had information available to them showing that this was a falsehood, that this was untrue, that this was a misunderstanding, and was otherwise incorrect.

Senator MURRAY. Mr. Chairman, I would request that the committee demand that these records in the possession of the Harness committee should be submitted to us for examination and for incorporation in the record.

Senator PEPPER. Mr. Chairman, on page A427 of the Congressional Record of January 26, in an address, "Extension of remarks," under the title "Socialized Medicine," by the Honorable Forest A. Harness in the House of Representatives, on Monday, January 26, 1948, Mr. Harness says, as follows:

> Mr. Speaker, I ask leave to extend my remarks in the Record, by including the following address delivered by me before the National Physicians and Surgeons Committee, Inc., Colorado Springs, Colo., on October 24, 1947.

Then, later, in the two paragraphs preceding the one I am going to read, it is inferred that this Tokyo mission was initiated by somebody in Washington. Then he uses these words, and I address them to Mr. Falk, and ask for his comment on them:

> Up to this point there has been no hint that the proposed health mission has been requested or urged, either by General MacArthur or any responsible Japanese sources. This suggestion came first from Mr. Stanchfield, who had been sent to Tokyo from Washington for that particular purpose.

Mr. FALK. What is that date?

Senator PEPPER. Those are the words of Mr. Harness.

Mr. FALK. What is the date?

Senator PEPPER. That is taken from the Congressional Record of January 26, 1948.

Mr. FALK. I mean the date of the speech. What is the date of the speech?

Senator PEPPER. The speech was delivered on October 24, 1947, by Mr. Harness, and put in the Record by Mr. Harness.

Mr. FALK. Senator, I cannot speak with confidence.

Senator PEPPER. I just say that the contrary is true, if I understood you; is that correct?

Mr. FALK. I cannot be sure of my own personal knowledge, but I believe that at least these two documents which have been read into the record were in Mr. Harness' possession before that date. One is the release from the War Department and the other the communication from General MacArthur, both of which directly contradict that statement.

Senator PEPPER. I just wanted to get your view on that.

Senator MURRAY. In other words, in this statement he was falsifying the record?

Mr. FALK. I do not know whether he was falsifying the record or whether he was merely repeating misinformation which was furnished him.

Senator MURRAY. If he knew the facts and then deliberately misrepresented them, he would be falsifying the record, would he not?

Mr. FALK. If he did know them personally and then proceeded to say that, that would be so. I believe these were available to his committee and staff and, I believe, to him.

Senator PEPPER. You put those in the record in this hearing today?

Mr. FALK. I believe one was read by Senator Donnell and the other by me. The release from the War Department is dated August 27, 1947, and the release from General MacArthur is dated August 31, 1947.

Senator DONNELL. Mr. Falk, the fact remains that you do not personally know what information has reached the Harness committee. That is correct, is it not?

Mr. FALK. I do not personally know from personally having been present.

Senator DONNELL. All right. And neither Mr. Harness nor any member of that committee has told you what had come before that committee, is that correct?

Mr. FALK. I believe it is of record that documents of these kind reach them.

Senator DONNELL. I am asking you whether any member of that committee has advised you as to what evidence has come before that committee.

Mr. FALK. Whether any member has?

Senator DONNELL. Yes.

Mr. FALK. No, sir.

Senator DONNELL. The further fact remains that in the Reader's Digest of December 1947 appears the article by Mr. Forest A. Harness, Member of Congress from Indiana, which I now offer for the record for whatever it may be worth, and ask that it be placed in the record at this point.

(The Reader's Digest article referred to is as follows:)

OUR MOST DANGEROUS LOBBY—II

(By Forest A. Harness, Member of Congress from Indiana)

[Forest A. Harness, who has represented the Fifth Indiana District in Congress since 1939, is chairman of the House Subcommittee on Publicity and Propaganda in the Executive Departments. The four other members of the committee are James W. Wadsworth and Henry J. Latham, Republicans; and Carter Manasco and J. Frank Wilson, Democrats. Frank T. Bow, of Canton, Ohio, is the committee counsel]

Probing the operations of "our most dangerous lobby,"[1] a congressional subcommittee, of which I am chairman, has uncovered startling evidence of attempts by Federal officials to make big Government bigger and to extend, by another vast grant of power, the authority of the state over the lives of all of us.

Our committee has found that Government employees are back of the campaign to pressure Congress into passing a national compulsory health insurance law. This campaign was planned inside the Government, on Government time, supported by the Government's publicity and propaganda machine and paid for by the taxpayer. Confronted with these facts our committee—Democrats and Republicans—voted unanimously to expose them and to turn the evidence over to the FBI and the Department of Justice for prosecution under the law which forbids Federal employees to use Federal funds to influence legislation.

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[1] See "Our Most Dangerous Lobby," the Reader's Digest, September 1947.

Of recent legislative proposals, none has stronger, more obvious appeal to the devotees of the all-powerful, all-supervising state than national compulsory health insurance, often described as "socialized medicine." Compulsory health insurance—cornerstone of every socialist regime—proposes to solve our health problems not from the community up but from Washington down. Instead of voluntary and group health insurance, backed where necessary by grants-in-aid, we would have a Federal law enforced by Federal agents. Estimates of its cost run as high as $7,000,000,000 a year. It would swell by many thousands the number of employees in the Federal bureaucracy.

Bills to launch plans of this sort were introduced in each of the last four sessions of Congress. Each time, Congress was subjected to intense, highly organized pressure in their behalf. Unconvinced of the scheme's workability, and unwilling to contribute on such a scale to bureaucracy's urge to expand, Congress resisted this pressure. But, without doubt, the heat will again be turned on Congress in January to pass an even bigger and costlier bill.

Our investigations revealed that headquarters for the drive for this scheme is in the Federal Security Agency in Washington. The FSA is already a vast social service establishment with 35,000 employees. Administration and enforcement of the health-insurance law would be added to its domain. Its size and power would thereby be immeasurably increased.

Government officials at the FSA supplied the law's out-in-front promoters with ammunition for their propaganda. They sent representatives abroad, at Government expense, to bring back data on how similar schemes work elsewhere; arranged a campaign to carry the idea to the various States; and even sent a mission, loaded with proponents of the idea, to work out a health program for Japan.

The files of the Social Security Administration in the FSA bulge with information favorable to the compulsory-insurance idea. The files and SSA's staff of experts have been at the service of those advocating the bill. Staff members largely drafted the present bill—as they had its predecessors. They wrote testimony for witnesses to read at Senate hearings. "The staff and resources of the Bureau of Research and Statistics in the Social Security Administration," we found, "were devoted freely to the preparation of pamphlets and propaganda literature for the CIO, AFL, and Physicians' Forum. Much of this material, prepared at Government expense, supported what certain witnesses referred to as 'socialized medicine.'" All opposing arguments were "dismissed contemptuously."

To add to the fund of material available, arrangements were made last spring to send an investigator to New Zealand, at Government expense, to bring back the story of that country's compulsory-health-insurance experiment. The man chosen for the mission has been "documented by the House Un-American Activities Committee for long association with Communist front and fellow-traveler organizations." Our exposure of the facts halted this junket.

To increase pressure for the scheme, Federal job-holders helped to set up two organizations—the Physicians' Forum and the Committee for the Nation's Health—and have been active in both.

The Physicians' Forum claims about 1,000 doctors in its membership, two-thirds of them in or near New York City. Its chairman, Dr. Ernest P. Boas, has been identified by the Committee on Un-American Activities as a member of eight Communist-front organizations. Under cross-examination at last summer's Senate hearings, he admitted that his organization is not registered as a lobby, although it had received and spent at least $10,000 "for the promotion" of the Wagner-Murray-Dingell compulsory-insurance bill.

The heads of both the New York and Washington offices of the Committee for the Nation's Health are formally registered with the Government as paid lobbyists. Chairman of the committee and one of its principal founders is Michael M. Davis, Ph. D., formerly employed by the Social Security Administration. Dr. Davis's son is an official of the Public Health Service lately assigned, at Government expense, to the British Ministry of Health in London to observe Britain's system of "socialized medicine."

On the eve of the introduction in Congress of a compulsory-health-insurance bill late in 1945, 10 of the most influential backers of the idea, all Government employees, met in Washington to plan a drive to stir support at the grass roots for the measure they had helped prepare. The device agreed on was "The Health Workshop." This, we found, was the name given to conferences, planned for numerous States, to indoctrinate leaders of farm and labor organizations, women's clubs, church groups and others. Instructions sent out from the Government for training Workshop leaders included "Techniques for the Organization of Citizens Groups"; "Formation of Pressure Groups"; "Methods of Bringing About Group Action."

This campaign was launched last year in Minnesota and North Dakota. Our committee held hearings on the Workshop conference which was held in Jamestown, N. Dak. Committee counsel Frank T. Bow brought out in the hearings that representatives of six Federal agencies, traveling on the Government, went from Washington and elsewhere to direct it. It was ostensibly devoted to a consideration of the health problems of North Dakota, but no North Dakota doctor was invited. The only doctors on hand were on the Federal pay roll—and they were not M. D.'s but Ph. D.'s.

In the literature sent in advance to each of the delegates were pamphlets published by the CIO, the AFL and the Physicians Forum, advocating compulsory insurance and urging pressure on Congress to get it. This literature was mailed from the Federal Security Administration at Government expense. No material opposing compulsory health insurance was sent to delegates or made available at the meeting. No speaker opposing it was invited or heard.

Before adjournment the delegates representing numerous State-wide organizations, voted to poll Congressmen and candidates on their stand on the national health program. They agreed to form the Dakota Action for Medical Care Council to coordinate and continue agitation. Our committee unanimously concluded that the Workship program "was calculated to build up an artificial, federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance."

The members of our committee, of both parties, also unanimously agreed that these efforts of certain Federal bureaucrats to organize pressure against Congress to advance their ideas and increase their authority are a threat to our representative institutions. We agreed that, with democracy almost everywhere under attack, these efforts must be exposed and fought. To that, we are sure, the American people will agree.

Senator DONNELL. Now I would like to read two things at this time. One is a further portion of this letter of September 9, 1947, from Mr. Harness to Congressman Taber. I read the first paragraph of it. He then proceeds as follows:

In a letter addressed to Mr. Watson B. Miller, Administrator of the Federal Security Agency, under date of August 6, 1947, the Secretary of War stated the objectives of the mission were "to consult with the Public Health and Welfare and with the Japanese Committee on Social Insurance and Japanese Council on Medical Care for the purpose of drafting a national-health bill which will incorporate a unified national-health program with a national medical-care program. This bill must be available to present to the Diet not later than October 1, 1947."

I deem it proper to bring this matter to your attention because it appears to me to involve a question of legislative policy for the consideration of the Appropriations Committee. All members of this mission are permanent, full-time employees of the Federal Government and are well known in the United States for their persistent agitation for a national system of socialized medicine to be achieved through a program of compulsory health insurance.

The members of the mission are Joseph W. Mountin, Associate Chief, Bureau of State Services, United States Public Health Service; Burnet M. Davis, surgeon, United States Public Health Service; Barkev S. Sanders, Chief, Health Studies Division, Bureau of Research and Statistics, Social Security Administration; and Francis A. Staten, Assistant Regional Director for Management, Federal Public Housing Authority.

This mission departed for Tokyo on August 28, 1947. We are informed that at a later date the mission will be expanded to include Mr. Arthur J. Altmeyer, Commissioner of the Social Security Administration; Mr. Wilbur Cohen, Assistant Director of the Bureau of Research and Statistics, and possibly Mr. I. S. Falk, Director of the Bureau of Research and Statistics.

In reply to allegations by the War Department that protests against this mission have been based on lack of information, please be advised that my statements are founded upon what purports to be the complete file of the War Department in this matter. These files indicate definitely that the plans for the mission were originated by key agitators for socialized medicine on the Federal pay roll in Washington and their collaborators on the Federal pay roll in Tokyo; that very close liaison was maintained among the two groups, and that the basic purpose of the mission is the establishment of socialized medicine in Japan.

In preparation for the mission, a civilian employee, Mr. Stanchfield, was sent to Tokyo to make a preliminary survey of social security and health needs. Thereafter Mr. Stanchfield proposed the mission to Arthur J. Altmeyer, Commissioner of the Social Security Administration, and on March 5, 1947, Mr. Altmeyer in a letter to the War Department designated the personnel to be included in the mission, and suggested Mr. William H. Wandel, Chief of the Program Division, Bureau of Unemployment Security, as a member, and suggested that Mr. Wandel precede the mission to Japan by about 3 months and that he should remain 3 months after the mission had completed its visit to Japan to finish up any necessary details, and he further suggested that while in Japan on the mission, Mr. Wandel serve as Chief, Social Insurance Division, Public Health and Welfare Section of the Supreme Command for the Allied Powers (SCAP).

It is apparent from the letter herein referred to from Mr. Altmeyer to the War Department that the personnel of the mission and the planning of its program was dictated and originated in and from the Social Security Administration in Washington. There is nothing in the entire record before us to indicate or suggest that the need for the mission was suggested originally either by General MacArthur or any responsible Japanese source. To the contrary, our records contain a letter under date of June 14, 1947, from William H. Wandel, Chief of the Social Security Division, public health and welfare section of SCAP, to I. S. Falk in Washington, outlining the real purposes of the proposed mission. In this letter Mr. Wandel said, in part:

"We now think that our need is for someone who is primarily not so much an economic analyst as one versed in health insurance. Health insurance is the major field of social security in Japan. * * * Permanent revision requires amalgamating national health insurance with health insurance, on a compulsory basis."

In a letter from William H. Wandel from Tokyo to I. S. Falk of the Federal Security Agency, Mr. Wandel exposed the fact that there were conflicts of interests as to the purposes to be accomplished when he stated:

"I find the work here very interesting and engrossing. One is reminded forcibly of the apparently universal character of the conflict of established interests, but nevertheless there are real possibilities for accomplishment. I am glad I came out."

It has also come to the attention of our committee that Dr. B. M. Davis, one of the members of the Tokyo mission returned only recently from London, where he was attached to the British Ministry of Health, to assist in the national program for socialized medicine in England. He is the son of Mr. Michael M. Davis, chairman of the executive committee of the Committee for the Nation's Health, the foremost lay organization agitating for socialized medicine in the United States, as embodied in the Wagner-Murray-Dingell bill. The Committee for the Nation's Health, as our previous reports have delineated, is the principal national organization in the United States engaged in distributing the propaganda of the Social Security Board supporting socialized medicine.

I feel strongly that the question fairly arises as to when these gentlemen work for the people of the United States who pay them? Our committee has already traced out their operations in New Zealand, in England, in Latin America, and finally in Japan. Personally, I feel that if the American taxpayers are supporting a world-wide movement for socialized medicine, then the people are entitled to know it and to know how much such international activities are costing them.

We have been investigating this situation for 6 weeks. Our conclusions to date are as follows:

1. That the health mission to Japan is composed entirely and exclusively of men long identified in the public record as advocates and proponents of socialized medicine not only in the United States but throughout the world.
2. That the real purpose of this mission is to lay the ground work for a system of socialized medicine in Japan.
3. That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington, and nowhere else.
4. That the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo by Federal employees sent from Washington for that particular purpose.

> 5. That Gen. Douglas MacArthur does not favor and does not approve any plan to establish compulsory socialized medicine in Japan.
>
> 6. That the dispatch of this mission to Tokyo for the purpose indicated in Mr. Wandel's letter to Mr. Falk under date of June 14, 1947, is a gross misuse of public funds.
>
> 7. That the real purpose of the mission is not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine.
>
> 8. That although the questions here involved are of a health and medical nature, the Surgeon General of the United States Army was not consulted in reference to the problems involved.
>
> I deem it inappropriate for Federal employees, at the expense of the American taxpayer, to travel throughout the world preparing or assisting in the preparation of legislation to be adopted by foreign countries when similar legislation, long pending, has not been approved by the Congress of the United States.
>
> We are continuing our investigation of the origins and real purposes of the Tokyo health mission. Meanwhile we believe that your committee would want to have these facts before it when the next appropriation bill comes up for the Public Health Service and the Social Security Board.
>
> I am most anxious to cooperate with your committee, and will be happy at any time to make available to you or your staff the documents assembled by the staff of my committee in regard to this matter.

The letter is signed "Sincerely yours, Forest A. Harness."

Mr. Falk. May I comment on that letter which you just read, Senator?

Senator Donnell. Yes, if you desire to comment on it.

Mr. Falk. I do.

Senator Donnell. Very well. You may.

Mr. Falk. And I hope that nothing that I say will be in any way interpreted as indicating anything but the highest respect for any committee of the United States Congress, or any subcommittee thereof, but I would like to comment on that letter, and if this is criticism, I think it is merely to indicate that Mr. Harness is not well served.

Senator Donnell. Might I ask, before you make these comments, whether, so far as you know, Mr. Harness has ever yet revoked any of these statements or contradicted any of the statements set forth in this letter of September 9, 1947?

Mr. Falk. I regret to say that so far as I know, he has not. However, I think that he should have before now.

Senator Donnell. Proceed.

Mr. Falk. In offering these comments for the record, I should like to state that they were prepared by people who know the facts about this mission better than I do, and with such participation as I could give on such items on which I have factual knowledge.

As you pointed out in reading the letter, Mr. Harness' letter contains eight specific conclusions. I would like to comment on each of the eight.

Senator Donnell. Very well.

Mr. Falk. In his letter of September 9, 1947, Mr. Harness states as follows:

> We have been investigating this situation for 6 weeks. Our conclusions to date are as follows:
>
> 1. That the health mission to Japan is composed entirely and exclusively of men long identified in the public record as advocates and proponents of socialized medicine not only in the United States but throughout the world.

I will comment on that as follows:

Our comment: The members of the social-security mission who actually went to Japan included Mr. William Wandel, on transfer from his position as Chief, Program Division, Bureau of Employment Security, Social Security Administration; Dr. Joseph W. Mountin, on reimbursable detail from his position as Associate Chief, Bureau of State Services, United States Public Health Service; Dr. Burnet M. Davis, on reimbursable detail from his position as surgeon, United States Public Health Service; Mr. Barkev S. Sanders, on reimbursable detail from his position as Chief, Division of Health and Disability Studies, Bureau of Research and Statistics, Social Security Administration; and Mr. Francis Staten, formerly Assistant Regional Director for management, Federal Public Housing Authority.

Mr. Wandel never, throughout more than 11 years' service with the Social Security Administration——

Senator DONNELL. I'm sorry. I did not understand the beginning of that sentence.

Mr. FALK. I will repeat it.

Mr. Wandel never, throughout more than 11 years' service with the Social Security Administration, worked on insurance against the costs of medical care. Mr. Wandel and Mr. Staten had taken no position on the question of health insurance and could not have been "long identified" as either "advocates or proponents of socialized medicine."

My quotes are from Mr. Harness' statement.

Senator DONNELL. When you finish your comment with respect to Mr. Wandel, I wonder if you would have any objection to my introducing a letter from him to yourself?

Mr. FALK. I shall refer to it.

Senator DONNELL. When you arrive at that point?

Mr. FALK. Yes. (Continuing): Both had had experience in other fields of social-insurance operation and administration.

May I inject a remark which seems not to have been given much publicity, with respect to General MacArthur's request and in connection with the composition of the mission in attempting to meet the general's request for a staff on the social-security front. It is not merely the health front. The health problems in this field, as they found out when they got there, as indicated by something which you read, were perhaps the most difficult problem or the most critical problem. But the recruitment had reference to the fact that General MacArthur's request was for people to tackle some very tough problems that they were confronted with there in Japan with respect to old-age insurance, invalidity insurance, unemployment insurance. and other forms of social security, as well as health insurance, which Japan has had since 1922.

Senator PEPPER. Excuse me, Dr. Falk. Do you not think that in the minds of the American people the patriotism of General MacArthur is immune against any insinuation that he is trying to impose any communistic or seemingly communistic scheme upon the people of Japan, and that he is intelligent enough not to be the dupe for anybody else that might have such designs?

Mr. FALK. I would think so, Senator, and yet I do not know what the intimation of the plain statement in some of these documents that have been referred to has been, saying these matters did not originate with General MacArthur and since, by his own statement, he has identified himself with them as having originated with him—in other words, there are many implications that he is the dupe of somebody over there or over here, and if that implication is a fair one I think I would like to associate myself with you in saying that I think it is most unfortunate.

Senator DONNELL. I may say there, Mr. Falk, I think it is perfectly clear from this letter of Mr. Harness' that there is not the slightest intimation of any sort against General MacArthur.

There is this statement, as I read before, and I am quoting:

> That the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo by Federal employees sent from Washington for that particular purpose.

And then there is the further statement, which is so clear that nobody can doubt the meaning of it, and which I quote exactly:

> That General Douglas MacArthur does not favor—and does not approve—any plan to establish compulsory socialized medicine in Japan.

We shall address ourselves in a few moments to the gentlemen from your department or the others on the mission with respect to that particular subject.

Mr. FALK. About health insurance?

Senator DONNELL. But it is perfectly clear here that there is no charge made by Mr. Harness in anything I have seen that General MacArthur favors the establishment of compulsory socialized medicine in Japan.

Mr. FALK. May I repeat, I have no question at all with respect to the establishment of health insurance in Japan. It was established in 1922. That law went into effect, I think, in 1926 or 1927, and subsequent legislation, in 1939, if I remember correctly—I think it was 1938—established an additional semivoluntary insurance plan, so that variously between forty-odd and sixty-eight-odd million people in Japan have been under health insurance in Japan. Therefore there cannot be, as far as I understand it, any question about establishing it in Japan.

Senator DONNELL. I see nothing in the letter from Mr. Harness which intimates directly or indirectly that General MacArthur favors compulsory medical service—nothing that justifies that implication.

Senator PEPPER. Mr. Chairman, I believe that the Senator from Missouri has placed his own interpretation upon the effect of the statement of Mr. Harness. I am afraid I do not put quite the same interpretation upon it, because I cannot reconcile Mr. Harness' charge, as it were, that General MacArthur, where he says that the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo—which means, of course, General MacArthur—by Federal employees sent from Washington for that particular purpose, with the idea that there was not some scheming going on, which they made General MacArthur the victim of, and secured his cooperation in. Because in the letter, if the authenticity of General MacArthur's statement, released by the War Department, dated August 31, 1947, is not questioned, General MacArthur says in so many words that the request originated with the Japanese, came to his headquarters, was transmitted by his headquarters to Washington, and Washington complied with the request of a fellow Government agency. So General MacArthur has either been duped by somebody, which I deem to be unlikely, or Mr. Harness and General MacArthur are not at one about the facts.

In his letter of August 31, 1947, General MacArthur says, and it has already been put into the record:

> I suggest that the above facts be furnished those who protest this mission. I am sure the protests are caused by lack of accurate information in the matter.

So I would prefer to believe that General MacArthur being on the ground, and fully cognizant of the matter, had closer access to the facts than perhaps Mr. Harness here in Washington.

Mr. FALK. May I proceed with my comments with respect to this letter?

Senator DONNELL. You may.

Mr. FALK. I was giving you the information about the members of this mission.

Referring still to the first conclusion of Mr. Harness' letter, which you read—that letter from Mr. Harness to Mr. Taber:

> Dr. Mountin is best known for his studies on public-health administration and Mr. Sanders for his studies of disability and costs of medical care. In these connections they have expressed themselves favorably on health-insurance programs for the United States . We are not informed as to whether or not Dr. Davis has supported health insurance.

Now, quoting the second conclusion from Mr. Harness' letter, which reads——

Senator DONNELL. Pardon me. Do you mind if at this point, in order to preserve what I think is the continuity, I read into the record a letter to yourself from Mr. Wandel, over in Tokyo?

Mr. FALK. Senator, I was going to comment on that since it comes up in connection with one of the latter specific conclusions.

Senator DONNELL. If you have no objection, I think it would be well to have this letter before us before you make your comments on it.

Mr. FALK. I do not mean that, Senator. I think the record will be more useful, for one reading and studying it, if that letter went in at the point where the discussion deals with conclusion No. 6, which deals specifically with Mr. Wandel's letter.

Senator DONNELL. It does?

Mr. FALK. Yes.

Senator DONNELL. All right.

Mr. FALK. Continuing with the second conclusion contained in Mr. Harness' letter of September 9, 1947:

> 2. That the real purpose of this mission is to lay the ground work for a system of socialized medicine in Japan.

Our comment: In reaching this conclusion, the Harness subcommittee is in disagreement with General MacArthur's statement of August 31:

> * * * The purpose of the mission from the United States is to advise with reference to the coordination and application of social-security measures which have been in practice in Japan for many years. In the aftermath of the war and the economic stringencies resulting therefrom the Japanese Government has found manifold difficulties in the implementation of its old health-security laws. It appealed to this headquarters for advice and assistance in consolidation and simplification of existing codes in view of the general revision in governmental structure now taking place.
>
> As the appropriate section of SCAP did not possess the expert ability called for, the United States Government's corresponding services were requested to lend competent personnel for a short period of time to consult with and advise in the premises. * * *
>
> * * * So far as this headquarters knows, there has been no slightest effort or thought on the part of the United States Government services to inject

themselves into the matter nor to impose any preconceived concepts or controversial issues such as the socialization of medicine in Japan, and their actions in making experts temporarily available represent nothing but health assistance in response to a normal request from a fellow governmental agency.

The Harness subcommittee has not stated its definition of "socialized medicine"—for which it alleges the mission was laying the ground work. This subcommittee conclusion does not indicate knowledge of the fact that Japan has had a system of health insurance in operation since 1926. In recent years some 68,000,000 persons have been members of the Japanese health-insurance system of a total population of about 72,000,000. Continuing with Mr. Harness' subsequent conclusions:

> 3. That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington, and nowhere else.
>
> 4. That the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo by Federal employees sent from Washington for that particular purpose.

Our comment: We have not seen the file of the War Department in this matter. The War Department announced on August 27, 1947, that the mission was being sent to Japan at the request of Gen. Douglas MacArthur. In a message to the War Department dated August 31, 1947, replying to Representative Harness' statements to the press criticizing the mission, General MacArthur again stated that SCAP had requested the organization of the mission.

Also, we are informed that the Surgeon General of the United States Army, testifying recently before the Harness committee, reported that General MacArthur had personally assured him that he and his staff in Japan had originated and initiated the idea of obtaining technical staff to review and advise on the Japanese social security and health program for SCAP.

The first survey by SCAP of the Japanese social-insurance program was made in the spring of 1946 by two members of a special labor advisory mission, Mr. Oscar Weigert and Mr. Tillman Sogge. Mr. Weigert was on the teaching staff of American University. Mr. Sogge was on detail from his position at the Budget Bureau, where he was responsible for work relating to industrial classification. The Social Security Administration had no connection with that mission.

At several times during 1946, the Social Security Administration was asked to suggest candidates for positions in the Public Health and Welfare Section, General Headquarters, SCAP. The War Department experienced considerable difficulty in recruiting for these (and other) positions. Late in 1946, Mr. Paul Stanchfield, Deputy Chief, Labor Division, Economic and Scientific Section, SCAP—who had been in Japan as a member of the staff working on labor and labor market problems—returned to the United States with authority from SCAP to recruit personnel for Colonel Sams, Chief of the Public Health and Welfare Section, SCAP.

Before joining the staff of SCAP, Mr. Stanchfield had been a senior member of the staff of Office of War Mobilization and Reconversion, and the Social Security Administration had no connection with his selection or appointment to SCAP staff. When Mr. Stanchfield returned to the United States in the late fall of 1946 for a few months, he had been deputized by SCAP to make an effort through personal contacts to attempt to recruit for the major unfilled jobs in the Public

Health and Welfare Section, SCAP, dealing with social security and health fields.

Mr. Stanchfield talked with Mr. Altmeyer and a number of senior members of the staff of the Social Security Administration. When he found no qualified persons who were willing to accept the jobs on a 2-year basis, as originally offered, Mr. Stanchfield suggested the formation of a temporary mission headed by Mr. Altmeyer to provide the necessary leadership and technical assistance. When the mission was proposed to Mr. Altmeyer, he said it might be possible if that was an arrangement which General MacArthur wanted. Mr. Stanchfield then communicated with Tokyo and obtained instructions to proceed with the plan for a social-security mission.

On March 5 Mr. Altmeyer wrote to Maj. F. B. Simmons, who had been assisting with the arrangements for the War Department, setting forth the conditions under which he would be willing to participate and to release staff to participate in the proposed mission. The arrangements were placed on a formal basis with a letter of April 14, 1947, from the Secretary of War to the Federal Security Administrator requesting the services of Mr. William Wandel to serve as Chief of the Social Security and Insurance Division, Public Health and Welfare Section of SCAP in Tokyo.

Then I quote the fifth conclusion contained in the Harness letter:

> 5. That Gen. Douglas MacArthur does not favor, and does not approve, any plan to establish compulsory socialized medicine in Japan.

Our comment: We are not informed as to General MacArthur's opinion as to the desirability of health insurance or of a program which the Harness subcommittee would regard as "compulsory socialized medicine." In his statement of August 31, 1947, General MacArthur made it clear that he did not regard it as the function of SCAP to impose any particular program on Japan, but that SCAP did wish to respond to the request of the Japanese Government for help in the implementation—and "consolidated and simplification"—of its established health-insurance and social-security laws.

Continuing on to Mr. Harness's conclusion No. 6:

> 6. That the dispatch of this mission to Tokyo for the purpose indicated in Mr. Wandel's letter to Mr. Falk, under date of June 14, 1947, is a gross misuse of public funds.

Our comment: Mr. Wandel's letter of June 14 to Mr. Falk refers to the problem of recruitment for the long-term positions on the staff of SCAP, and this request had no bearing on the proposed mission. In this instance, the letter plainly explains that one of the immediate needs was for someone who had specialized in health insurance rather than a general economic analyst. The statement quoted earlier in the Harness letter, that "health insurance is the major field of social security in Japan" is not a statement of "purposes" but of fact as to social security in Japan. Likewise the statement quoted earlier in the letter about "amalgamating national health insurance with health insurance" is Mr. Wandel's judgment, while on the ground, as to a method of dealing with practical problems in a country which already had two systems of health insurance.

Mr. Wandel's letter also contains a reference to the problems "of an emergency character" facing the Japanese Government and SCAP. "The emergency," Mr. Wandel said, "is due to the critical condition of the Voluntary National Health Insurance Association, the financial resources of which have not kept pace with the increased costs of medical service." The only purpose indicated in Mr. Wandel's letter is the function of SCAP'S technical staff giving technical advice with regard to problems confronting General MacArthur's staff.

The public funds used to pay the salaries and other expenses of the mission were provided by the War Department, in response to a request from General MacArthur, who presumably regarded the purpose as a proper function of SCAP.

Shall I proceed, or did you wish to introduce the letter at this point, Senator?

Senator DONNELL. The letter that I refer to is the one that you are speaking of, June 14, 1947.

Mr. FALK. I have only two further remarks to make, both of them brief, if I may.

Senator DONNELL. It might be well, however, to insert, if you have no objection, at this point that letter in full, Mr. Falk.

Mr. FALK. This would be the proper place to insert it, if you wish to do so.

Senator DONNELL. It will take only a couple of minutes to read it. It is dated June 14, 1947.

(The letter above referred to is as follows:)

GENERAL HEADQUARTERS,
SUPREME COMMANDER FOR THE ALLIED POWERS,
PUBLIC HEALTH AND WELFARE SECTION,
SOCIAL SECURITY DIVISION,
June 14, 1947.

DR. I. S. FALK,
Director, Bureau of Research and Statistics, Social Security Administration, Federal Security Agency, Washington, D. C.

DEAR MR. FALK: We are still recruiting for vacancies in the Social Security Division of the Public Health and Welfare Section. Yesterday we thought all vacancies filled; today we know that a person who was to fill a position of economic analyst will not be able to come. Our organization of the Division follows this pattern:

Chief: William H. Wandel.
Deputy Chief: George F. Pollock.
Branches:
  Social Insurance (other than Health Insurance): L. R. Anton, P. Sullivan.
  Health Insurance: L. Janis.
  Economic Analysis: G. L. Rohrlich—vacancy (CAF-12).

We now think that our need is for someone who is primarily not so much an economic analyst as one versed in health insurance. Health insurance is the major field of social security in Japan. Existing problems are both of an emergency character and of permanent reformulation of the program.

The emergency is due to the critical condition of the voluntary national health insurance associations, the financial resources of which have not kept pace with the increased costs of medical service. Permanent revision requires amalgamating national health insurance with health insurance, on a compulsory basis. In view of the magnitude of the job and the amount of field work necessary to gain an understanding of these systems, Dr. Janis needs assistance. While the need for this job should and probably will be recognized by the establishment of a new position, we are not planning now to take the time necessary to write up a new job description and set up a new vacancy. Rather, we wish to fill the existing vacancy with someone who can properly fill it, but who also will be qualified to give special attention to the problems in health insurance.

I believe that special consideration is being given this Division to permit us to recruit for a contract period of 1 year rather than for the standard 2 years.

I hope you can recommend someone for this job. I would be glad to know of your recommendations, but do not think you should hesitate to suggest to anyone you would recommend that he get in direct touch with Maj. Franklin B. Simmons, Civil Affairs Division, War Department, Room 38859, Pentagon Building, Extension 3445. (I am sending a copy of this letter to him and to Wilbur Cohen.)

I find the work here very interesting and engrossing. One is reminded forcibly of the apparently universal character of the conflict of established interests, but nevertheless there are real possibilities for accomplishment. I am glad I came out.

Sincerely,

William H. Wandel, *Chief.*

Mr. Falk. May I say at this point for the record, Senator, that I never wrote any reply to Mr. Wandel in connection with this letter. In fact, I had no communication with him while he was in Japan, so that with respect to those who have found in excerpts from this letter some intimation about my influence on recruiting his staff, it might be well to indicate for the record that I gave him no reply and gave him no particular suggestions as to how to meet his recruitment.

May I resume my comments, with respect to the last two points?

Senator Donnell. Do you mind telling us why you never sent him a reply?

Mr. Falk. I immediately sent this around to various people, to try to find the names of people who might be available to meet his needs. We were not very successful, and I believe I had a follow-up call from Major Simmons, who is referred to in the letter, and I told him about one or two or three people whom we were exploring, whom we were thinking over, talking about, as to whether they might fill Mr. Wandel's needs. I think I mentioned two names to him—I may have made some mention to him about them. At any rate, I passed this around to the staff and asked them for suggestions, and I believe that before we ever got anything, before we found anyone that we could send to Mr. Wandel, the other developments concerning this mission arose and called or headed the whole thing off.

Senator Donnell. All right.

Mr. Falk. With respect to the last two conclusions in Mr. Harness' letter:

> 7. That the real purpose of the mission is not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine.

Our comment: The Harness subcommittee has not defined what it means by "a compulsory system of socialized medicine." This conclusion appears not to take into account the fact that Japan has had a system of health insurance in operation since 1926. Japanese leaders were proposing modifications in that system, and according to General MacArthur—

> appealed to this headquarters (SCAP) for advice * * *. As the appropriate section of SCAP did not possess the expert ability called for, the United States Government's corresponding services were requested to lend competent personnel * * *.

Proceeding to Mr. Harness' eighth and final conclusion:

> 8. That although the questions here involved are of a health and medical nature——

Senator Pepper. Before you pass on to that next point, with respect to the point that you just discussed—that charge that you read that Mr. Harness made, and which you have just described—the charge that the real purpose of the mission is not to assist Japan in working out her basic problems in health and welfare but to force upon that country compulsory socialized medicine, that is directly contradicted by General MacArthur's communication of the 31st of August, 1947.

Mr. FALK. Yes, sir; as well as by the facts in the record that Japan had long had a system of compulsory health insurance and a system of voluntary or semivoluntary health insurance, which were substantially coordinated or amalgamated—I am not sure which—during the war.

Senator PEPPER. Now, if any system is to be implemented in Japan, it would certainly have to have the approval and the very definite authority of General MacArthur, and it is unlikely that your Social Security Agency in Washington could force upon Japan anything that General MacArthur did not approve of in the first place.

In the second place, General MacArthur would not want to enforce anything upon the Japanese people which he did not think was proper.

Mr. FALK. Senator, I think the plain fact is that General MacArthur needed technical aid in facing problems with which he was confronted in dealing with the Japanese Government and their social-security program. He asked for such technical help. We were very glad to give it to him, through the intermediation of the War Department, and, as I shall show in a moment, I can indicate what General MacArthur thought about the work that the mission did.

May I return now to the conclusion of these points in Mr. Harness' letter to Mr. Taber?

Senator DONNELL. Yes.

Mr. FALK. This is the last conclusion and the last comment:

> 8. That although the questions here involved are of a health and medical nature, the Surgeon General of the United States Army was not consulted in reference to the problems involved.

Our comment: We do not know whether the Surgeon General of the United States Army was or was not consulted. The War Department could advise as to the precise responsibilities of the Surgeon General of the United States Army. We have thought his responsibility related to the health and medical care of members of the United States Army, not to the policies of our occupying forces or to the legislative programs of occupied countries. SCAP, we understand, is responsible to the Far Eastern Commission and not to the War Department of the United States Government. Now, I would like to follow that by two brief items which bear on these matters covered in that letter and our comments on them.

The United States Department of the Army furnished us with the following excerpts from recent exchange of cables with General MacArthur concerning the conduct of mission personnel and their report.

(The cables above referred to are as follows:)

> December 11, 1947—Cable to General MacArthur re Social Security Mission to Japan:
>
> "Congressional investigation of Harness House subcommittee has approached members subject mission requesting information concerning recommendations submitted in mission report to SCAP. On basis commitments to SCAP and their and Army Department understanding that only SCAP can release report, mission members have declined to comment on report content; further, no copy of report available Washington. Request your recommendation procedure to be followed by individual members of mission as well as Army Department, keeping

in mind prospect Army Department momentarily being requested by subcommittee furnish report copy. To date no information re recruitment and purpose of mission withheld from subcommittee and Army Department desires to cooperate with subcommittee to fullest extent."

December 14, 1947—Cable from General MacArthur:

"With reference to your cable your understanding concerning conduct of members of mission and release of report as outlined in radio correct. Report of mission invited to this theater by SCAP are made to him for his consideration and may not be released or commented on by members of his mission until authorized by SCAP. Report of social security mission is now under study by this headquarters. This study will be completed in approximately 30 days and until such time as study is completed there will be no release of the report or its contents. However, you may inform congressional investigator of Harness House subcommittee or other interested agencies that the scope of this mission did not include propaganda for nor the imposition of socialized medicine in Japan. Reference my radio statement dated September 1 (sent August 31) made by Z20007. Conduct of this mission while in this theater was in accordance with that policy. They engaged in no propaganda activities nor is their report concerned in any way with an imposition of socialized medicine on Japan, but is confined to recommendations to simplify and coordinate existing social insurances to make them more effective."

Mr. FALK. I would be glad to furnish the committee any further information.

Senator PEPPER. What is the date of that communication from General MacArthur?

Mr. FALK. December 14, 1947.

Senator PEPPER. December 14, 1947-

Mr. FALK. Yes, sir.

Senator PEPPER. Well, that is then some little time after October 24, 1947. Do you suppose that could have escaped the attention of Mr. Harness so that he could not have known about that communication from General MacArthur when he made this speech of his on October 24, 1947, that I referred to in the Congressional Record of January 26, 1948?

Mr. FALK. Senator, there are so many items in this whole episode that are inexplicable to me that I would not know how to answer your question?

Senator DONNELL. Have you finished, Mr. Falk?

Mr. FALK. I merely wanted to add, Senator, that in the course of these comments I have made various references to documents and memoranda, all of which we would be glad to furnish to your committee—any part of them or all of them—if you would like to have them.

Senator DONNELL. I move, Mr. Chairman, that Mr. Falk be given permission to incorporate each and every one that he deems relevant.

Senator SMITH. You mean, at his discretion?

Senator DONNELL. Yes; whatever he thinks is proper should be admitted.

(Subsequently, Mr. Falk submitted the following papers:)

NOTES CONCERNING THE SOCIAL SECURITY MISSION TO JAPAN

In view of the incorrect accounts that have been given of the genesis of the social-security mission to Japan, and the erroneous interpretations that have been placed on its purposes, the Social Security Administration welcomes this opportunity to record the facts about its participation. The major facts are, in essence, as follows:

1. Mr. Stanchfield, of General MacArthur's staff in Tokyo, came to the United States to recruit personnel for their staff on social-security and health matters. The Social Security Administration had had no responsibility for Mr. Stanchfield's appointment to the Tokyo staff, or for earlier studies on Japanese social-security problems.

2. Failing to recruit some of the technical staff members needed, Mr. Stanchfield—with the approval of General MacArthur (SCAP)—proposed to Mr. Altmeyer that the latter serve as chief of a special short-term mission. Mr. Altmeyer accepted the invitation on terms cleared with the War Department.

3. In accordance with SCAP's desires, the War Department requested the loan of certain personnel from the Federal Security Agency, on reimbursable detail. One of these officers, Mr. Wandel, went to Japan in May 1947, in advance of others, and later was acting head of the mission in Japan. Three other Federal Security Agency officers (and a fourth person recruited by the War Department) left for Tokyo in August 1947, as an advance party of the special mission. Owing to subsequent delays in Mr. Altmeyer's availability, he did not go to Japan.

4. The special mission was advisory to General MacArthur and his staff on the broad field of social security, including health insurance, which Japan has had for a long time. Their system of compulsory health insurance was enacted in 1922 and their system of subsidized quasi-voluntary national health insurance was enacted in 1938. Reorganization of their social-security programs was under consideration by the Japanese Government in 1946 and 1947, and the needs and proposals had to be evaluated by SCAP.

5. Congressman Harness criticized the mission to Japan in a public release on August 27, 1947, alleging that the idea for it originated in the Bureau of Research and Statistics of the Social Security Administration and that its purpose was to socialize medicine in Japan, and requesting the postponement of its departure for Japan. The War Department issued a release on August 27, 1947, stating that the mission had been requested by General MacArthur and that it was to advise him. General MacArthur transmitted to Washington a statement about the mission, and this was released by the War Department August 31, 1947, repeating that SCAP had requested personnel from the United States Government, to consult with and advise SCAP.

6. The mission prepared a report for SCAP, and its members returned to the United States in November 1947. The mission was dissolved by War Department letter of December 22, 1947, to Mr. Altmeyer.

7. Thus the plain facts are that the need and the concept for a mission to Japan originated with SCAP, and its purpose was to give such assistance to SCAP as was requested on social-security problems. General MacArthur has so stated on several occasions.

SUMMARY OF SIGNIFICANT DEVELOPMENTS RELATING TO *SCAP* SOCIAL SECURITY MISSION TO JAPAN

May 1946.—Mr. Oscar Weigert and Mr. Tillman Sogge, members of the Labor Advisory Committee (Tokyo, Japan), which had submitted to SCAP a Report on the Japanese Social Insurance Program, came in to see Mr. Arthur J. Altmeyer (Commissioner for Social Security) and Mr. Wilbur J. Cohen (Assistant Director, Bureau of Research and Statistics) on their return from Japan. During the discussion Mr. Altmeyer and Mr. Cohen were asked by Mr. Weigert and Mr. Sogge to suggest candidates for positions in the Public Health and Welfare Section, General Headquarters, Supreme Commander for the Allied powers, Tokyo. Mr. Weigert and Mr. Sogge sent Mr. Altmeyer a copy of Report on the Japanese Social Insurance Programs, prepared by the Labor Advisory Committee, Tokyo, Japan. Also in the spring of 1946 Mr. Paul Stanchfield, Deputy Chief, Labor Division, Economic and Scientific Section, SCAP, conferred with Mr. Altmeyer and Mr. Cohen regarding technical assistance in social security undertakings by SCAP.

August 2, 1946.—A letter from Mr. Sogge of the United States Bureau of the Budget, to Mr. Cohen lists four positions ranging in salary from $5,905 to $8,877, plus 25 percent overseas allowance, in the field of social security in Japan for which the War Department had asked him to assist in soliciting candidates. Mr. Sogge requested that publicity be given these positions among State agency and social security regional office staff.

Late in 1946.—Mr. Stanchfield returned to the United States with authority from SCAP to recruit personnel for Colonel Sams, Chief of the Public Health and Welfare Section of SCAP. When he had difficulty recruiting people to go to

Japan to take jobs in the Social Security Division, Mr. Stanchfield suggested the formation of a temporary mission headed by Mr. Altmeyer to provide the necessary leadership and technical assistance. Mr. Cohen discussed this with Mr. Altmeyer who said it might be possible if that was what General MacArthur wanted. Mr. Stanchfield communicated with Tokyo and obtained instructions to proceed with the plan for a social security mission which he and Major Simmons of the War Department discussed with Mr. Altmeyer before Mr. Stanchfield returned to Tokyo.

March 5, 1947.—Mr. Altmeyer's letter of this date to Major Simmons records his reaction to the arrangements for the mission proposed by the War Department through Mr. Stanchfield. (Attached.)

April 14, 1947.—The Secretary of War wrote the Administrator requesting the services of Mr. Wandel to serve as Chief of the Social Security and Insurance Division, Public Health and Welfare Section of SCAP in Tokyo, Japan, for a period of approximately 60 days, on a reimbursable basis with the War Department paying all travel expenses. On April 17, the Secretary amended his previous letter by requesting Mr. Wandel for 6 months. (Attached.)

April 21, 1947.—The Acting Commissioner replied to the Secretary of War stating that a reimbursable detail was not feasible but we would agree to Mr. Wandel's transfer for the period involved under section 2 of Executive Order 9711. (Attached.) (Mr. William H. Wandel, Chief, Program Division, Bureau of Employment Security, P–7 $8,778.40 transferred to the War Department pay roll May 1, 1947. He is scheduled to return to the pay roll of the Social Security Administration in January 1948.)

July 17, 1947.—A teleconversation was held between Tokyo and Washington. Col. C. F. Sams, Mr. William Wandel, Mr. George Pollock, Mr. George Rohrlich and Mrs. Leone M. Moor participated in Tokyo and Maj. F. B. Simmons, Mr. Wilbur J. Cohen, and Miss M. Mulliner participated from Washington. The purpose of this teleconversation was to obtain recommendations from SCAP with respect to the proposed social security mission to Japan.

July 18, 1947.—A memorandum from Mr. W. L. Mitchell (Acting Commissioner for Social Security) to Mr. Watson B. Miller (Federal Security Administrator) summarized the tentative conclusions reached on July 17 through a teleconference between officials in Washington and the War Department staff located in Tokyo, including the urgent request from Tokyo that the health insurance part of the mission arrive not later than September 1 "even if Mr. Altmeyer cannot accompany." This memorandum requested the Administrator's approval of the steps set forth to get additional technical people to Tokyo. (Attached.)

July 21, 1947.—The Acting Administrator, Mr. Collins, approved the steps set forth in the July 18 memorandum on the understanding that the additional Federal Security Agency staff people were to serve in an advisory capacity at the request of the War Department and with the War Department bearing the expenses involved.

August 4, 1947.—Miss Huffman, investigator for the Harness committee, requested information for the Congressman concerning the staff members who were going to Japan, stating it was because of the interest of Congressman Harness in foreign travel. She said, however, that the Congressman had not asked her to look into such foreign travel as Miss Hoey's trip to England and France.

August 6, 1947.—Secretary of War wrote the Administrator requesting that the services of Dr. Mountin, Dr. Davis, and Mr. Sanders be made available to the War Department for approximately 60 days beginning on or about August 28, 1947, on a reimbursable basis pointing out that their services were desired by the supreme commander, Allied Powers in Tokyo, to participate in the Social Security and Insurance Mission. (Attached.)

August 12, 1947.—A copy of the Secretary of War's letter of August 6 requesting the services of Drs. Mountin and Davis and Mr. Sanders was sent to Miss Huffman for Congressman Harness as requested.

August 13, 1947.—The Administrator replied to the Secretary of War agreeing to make available the services of the two Public Health Service and one Social Security man requested, on a reimbursable basis for the salaries, with transportation expenses and per diem being paid directly to them by the War Department. (Attached.) (Mr. Barkev S. Sanders, Chief, Health Studies Division, P–6, $7,820.40, Bureau of Research and Statistics, was the Social Security Administration man loaned to the War Department. The Social Security Administration was reimbursed for salary in the gross amount of $1,774.52 from August 28 through November 17, 1947, covering the period Mr. Sanders was with the War Department. The War Department paid all travel and subsistence costs directly to Mr. Sanders.)

August 26, 1947.—Mr. Altmeyer conferred with Dr. Mountin and Mr. Sanders preparatory to their departure for Tokyo and provided them with a summary of the conference, a copy of which is attached. It was pointed out at this conference that pending receipt of the over-all report and recommendations from the Social Security Division of SCAP, plans with respect to other aspects of the mission would be held in abeyance.

Materials were received from the Social Security Division, SCAP, with the advice that further work was being done and the body of the Division's report would be rounded out considerably by the time the mission personnel on health insurance arrived in Tokyo. A copy of letter to Mr. Wandel acknowledging receipt of this material dated August 27, 1947, is attached. (Attached.)

August 27, 1947.—Representative Forest A. Harness, chairman of the Subcommittee on Publicity and Propaganda in the Executive Departments, in a statement to the press charged that the mission to Japan originated in the Bureau of Research and Statistics of the Social Security Board, and that the purpose of the mission was to advance socialized medicine in Japan. (Copy attached.)

August 27, 1947.—The War Department in Washington released a press statement concerning the departure of Mountin, Davis, Sanders, and Staten for Tokyo and saying "General MacArthur last April requested Mr. Altmeyer be invited to head a six-man mission that would visit Japan in September for a period of 30–90 days." (Attached.)

August 28, 1947.—Mr. Sanders, Dr. Mountin, and Dr. Davis left Washington for Japan. Mr. Staten joined them in San Francisco.

August 31, 1947.—The War Department released an incoming clear message from SCAP, Tokyo, Japan, signed "MacArthur" concerning the objective of the Social Security mission, containing the statement "So far as this headquarters knows there has been no slightest effort or thought on the part of the United States Government services to inject themselves into the matter nor to impose any preconceived concepts or controversial issues such as the socialization of medicine on Japan, and their actions in making experts temporarily available represent nothing but healthy assistance in response to a normal request from a fellow governmental agency." (Attached.)

September 9, 1947.—Congressman Harness sent the chairman of the Committee on Appropriations a letter relating to Special Health Mission to Tokyo and advising that the Harness subcommittee had been investigating social security in foreign countries, and setting forth eight conclusions to date. A copy of this letter is attached together with our factual statements regarding the eight conclusions and certain other significant statements in the letter.

December 11, 1947.—Mr. Altmeyer wrote the War Department pointing out that Messrs. Wandel, Sanders, Staten, and Drs. Mountin and Davis have returned to the United States and submitted their reports in Tokyo to Colonel Sams, Chief of the Public Health and Welfare, SCAP; and under the circumstances the mission appears to be completed and his responsibility ended. (Attached.)

United States Department of the Army furnished us with following excerpts from recent exchange of cables with General MacArthur concerning conduct of mission personnel and their report.

December 11, 1947.—Cable to General MacArthur re Social Security mission to Japan: "Congressional investigation of Harness House subcommittee has approached members subject mission requesting information concerning recommendations submitted in mission report to SCAP. On basis commitments to SCAP and their and Army Department understanding that only SCAP can release report, mission members have declined to comment on report content; further, no copy of report available Washington. Request your recommendation procedure to be followed by individual members of mission as well as Army Department, keeping in mind prospect Army Department momentarily being requested by subcommittee furnish report copy. To date no information re recruitment and purpose of mission withheld from subcommittee and Army Department desires to cooperate with subcommittee to fullest extent."

December 14, 1947.—Cable from General MacArthur: "With reference to your cable your understanding concerning conduct of members of mission and release of report as outlined in radio correct. Report of mission invited to this theater by SCAP are made to him for his consideration and may not be released or commented on by members of his mission until authorized by SCAP. Report of Social Security mission is now under study by this headquarters. This study will be completed in approximately 30 days, and until such time as study is completed there will be no release of the report or its contents. However, you may inform congressional investigator of Harness House subcommittee or other interested agencies that the scope of this mission did not include propaganda for nor the imposition of socialized medicine in Japan. Reference my radio statement dated September 1 (sent August 31) made by Z20007. Conduct of this mission while in this theater was in accordance with that policy. They engaged in no propaganda activities nor is their report concerned in any way with an imposition of socialized medicine on Japan, but is confined to recommendations to simplify and coordinate existing social insurances to make them more effective."

December 15, 1947.—Mr. Altmeyer, as Acting Administrator, wrote Congressman Harness pointing out that Messrs. Wandel and Sanders, of the Social Security Administration, and Dr. Mountin, of the Public Health Service, who had been requested to appear before the Harness subcommittee on December 16, were subject to the regulations of the Department of the Army insofar as their participation in the work of the Social Security mission to Japan was concerned. He pointed out that in his capacity as nominal head of the social-security mission and as Acting Federal Security Administrator he desired to interpose no objection to the committee's having all the information which it might request. (Attached.)

December 16, 1947.—Mr. Wandel, Mr. Sanders, and Dr. Mountin appeared before the Harness subcommittee and the first two testified about the Social Security mission.

December 22, 1947.—Letter from Colonel Hodges, War Department Special Staff, to Mr. Altmeyer, states "we wish to advise you that your responsibility for the mission is now over * * *." (Attached.)

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
Washington, D. C., March 5, 1947.

Maj. F. B. SIMMONS,
Personnel and Training Branch, Civil Affairs Division,
War Department, Washington, D. C.

DEAR MAJOR SIMMONS: This is to indicate my reaction to the arrangements proposed by your office, through Mr. Stanchfield, for a social-security mission to Japan.

As I understand it, the purpose of the mission would be to assist SCAP in evaluating social-security programs now in existence in Japan and to advise SCAP regarding pending or proposed measures to achieve a permanent, sound, social-security system for that country.

I should be glad to serve as nominal head of the mission and would hope that I could spend at least a month in Japan, probably during late August and September. I would be accompanied by Mr. Wilbur J. Cohen, the Assistant Director of Research and Statistics of the Social Security Administration.

I would want Mr. William H. Wandel, Chief of the Program Division, Bureau of Employment Security, to serve on the mission. In order to do necessary preparatory work, he should precede us to Japan by about 3 months and should remain for about 3 months after our visit in order to finish up any necessary details.

I should think it advisable, and would recommend, that while in Japan on the mission, Mr. Wendel also serve as Chief, Social Insurance Division, Public Health and Welfare Section, staff of the supreme commander. If such an arrangement can be made, I believe it would greatly facilitate the preparatory background work to be done and add to the success of the mission.

I would recommend that there be included in the mission a person specially qualified on public welfare to cover the field of assistance, relief, and family and child welfare services.

I would also recommend that Mr. Anton and Dr. Lee Janis be included in the mission and that, insofar as possible, the services of Mr. Stanchfield be made available to the mission.

I am leaving next week to go to Geneva, Switzerland, as secutive secretary of the Preparatory Commission for the International Refugee Organization. I shall return to Washington about August 1. In the meantime, if you desire that the Social Security Administration help you in any way, either along the lines outlined above or in some other manner please get in touch with Mr. Wilbur J. Cohen (National War Agencies, extension 3377).

Sincerely yours,

A. J. ALTMEYER, *Commissioner.*

WAR DEPARTMENT,
Washington, D. C., April 14, 1947.

Hon. WATSON B. MILLER,
Administrator, Federal Security Agency,
Washington, D. C.

DEAR MR. ADMINISTRATOR: It is requested that the services of Mr. William Wandel, Chief, Program Division, Bureau of Employment Security, Social Security Administration, P-7 at $8,778 per annum, be made available to the War Department for a period of approximately 60 days, effective as soon as possible, on a reimbursable basis.

It is desired to have Mr. Wandel serve as Chief, Social Security and Insurance Division, Public Health and Welfare Section, Tokyo, Japan, presently established at CAF-14. There is no qualified employee of the War Department available for this assignment.

Reimbursement for the salary of Mr. Wandel will be made upon receipt of Form 1080 by the Civil Affairs Division, War Department Special Staff. Travel expenses incurred as a result of this detail will be paid direct by the War Department.

Sincerely yours,

ROBERT P. PATTERSON,
Secretary of War.

WAR DEPARTMENT,
Washington, D. C., April 17, 1947.

Hon. WATSON B. MILLER,
Administrator, Federal Security Agency,
Washington 25, D. C.

DEAR MR. ADMINISTRATOR: Reference is made to my letter of April 14, 1947, requesting the services of Mr. William Wandel, chief, Program Division, Bureau of Employment Security, Social Security Administration, on a reimbursable detail basis.

We desire to retain the services of Mr. Wandel for a period of 6 months rather than 60 days as requested in my previous letter. Your cooperation in making Mr. Wandel available to the Department will be appreciated.

Sincerely yours,

ROBERT P. PATTERSON, *Secretary of War.*

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
Washington, D. C., April 21, 1947.

The honorable the SECRETARY OF WAR,
Washington, D. C.

DEAR MR. SECRETARY: Your letters of April 14 and April 17 addressed to the Federal Security Administrator requesting the reimbursable detail of Mr. William Wandel for a period of 6 months have been referred to me for reply. I regret that the fiscal situation of the Social Security Administration will not make feasible a reimbursable detail. However, we do consent to Mr. Wandel's transfer under section 2 of Executive Order 9711 (issued April 12, 1946).

Representatives of this office, upon contacting Major Simmons, of your Department, have been informed orally that this change will be acceptable to the War Department. If it is acceptable to you, Mr. Wandel's transfer may be made effective as soon as possible. We shall appreciate receiving an indication of the date upon which the transfer is desired.

As you stated in your letter, Mr. Wandel is now chief, Program Division, Bureau of Employment Security, Social Security Administration, P-7, $8,778 per annum. We understand that the War Department desires to use his services as chief, Social Security and Insurance Division, Public Health and Welfare Section, Tokyo, Japan, a position presently established at CAF-14.

In accordance with the provisions of Executive Order 9711 we shall hold Mr. Wandel's position for his return. It is understood that his services will be needed for a period of about 6 months.

Sincerely yours,

W. L. MITCHELL, *Acting Commissioner.*

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
July 18, 1947.

Interoffice communication.

To: Mr. Watson B. Miller, Administrator, Federal Security Agency.
From: W. L. Mitchell, Acting Commissioner.
Subject: Status of Japanese Social Security Mission.

This is a further report about development concerning a Japanese Social Security Mission on which we would like to have your concurrence so we can proceed along the lines indicated. On the evening of July 7 a telephone conference was held between Maj. F. B. Simmons, of the Civil Affairs Division of the War Department, Mr. Cohen and Miss Mulliner, of the Social Security Administration with Colonel Sams, Mr. William Wandel, and others located in Tokyo who are concerned with the Social Security Mission to Japan. This exchange of questions and answers furnished us with current and concrete information which we had not had previously. The pertinent information is contained in the following statement from Tokyo: "Urgent that mission arrive not later than September 1, even if Mr. Altmeyer cannot accompany mission at that time. Desire mission for 60 days and purpose of mission to be to consult with the Public Health and Welfare Division and with Japanese Committee on Social Insurance and Japanese Council on Medical Care for purpose of drafting a national health bill which will incorporate a unified national health-insurance program with a national medical-care program. This bill must be available to present to Diet not later than October 1. We deem it important to get Dr. Perrott and others familiar in this field, together with Mr. Cohen. Japanese groups continuing studies. Report by Social Security Division should be completed shortly after August 1 and can be sent to Cohen."

Our reply to above was that on the basis of this telephone conference steps will be taken to get health insurance part of mission under way by September 1, to be followed as soon as possible by the rest of mission, according to the need indicated by their report and recommendations.

In addition to the above, the exchange of questions related primarily to the report which is being prepared by the Social Security Division there, and the individuals to be attached to the mission. The following understandings were reached on these points:

1. That their report will cover review of all existing social-security programs, major problems, and tentative recommendations, as well as recommendations concerning relations of social insurances with other forms of social security. They were requested to forward to Mr. Cohen by the first week in August 5 copies of this report, to be used as the basis for planning the other aspects of the mission.
2. Major Simmons and Mr. Cohen will take immediate steps to get necessary agreement regarding the health-insurance personnel of the mission in order to have them under way by September 1. The people to be considered for such staff will be Perrott, Sanders, Mountin, Klem, Louis Reed, and other technical people.
3. The salaries and expenses of the mission personnel will be borne by the War Department.

I will be glad to try to supplement this memorandum with any other information you may wish. As you can see, the timetable obtained in the exchange of information last evening makes it necessary to make decisions promptly in order to get this group of personnel processed and in Tokyo by September 1. I have asked Miss Mulliner to keep in touch with Mrs. Woodward on developments regarding the mission.

W. L. MITCHELL.

WAR DEPARTMENT,
Washington, D. C., August 6, 1947.

MR. WATSON B. MILLER,
Administrator, Federal Security Agency,
Washington 25, D. C.

DEAR MR. ADMINISTRATOR: It is requested that the services of Mr. Joseph W. Mountin, medical director, $9,211 per annum; Mr. Burnet M. Davis, surgeon, $5,821.50 per annum, both of the United States Public Health Service; and Mr. Barkev S. Sanders, Chief, Health Studies Division, Bureau of Research and Statistics, $7,820.40 per annum, of the Social Security Administration, be made available to the War Department for a period of approximately 60 days, beginning on or about August 28, 1947, on a reimbursable basis.

The services of Messrs. Mountin, Davis, and Sanders are desired by the Supreme Commander, Allied Powers in Tokyo, Japan, to participate in a Social Security and Insurance Mission; the objectives of which are to consult with public health and welfare and with the Japanese Committee on Social Insurance and Japanese Council on Medical Care for the purpose of drafting a national health[1] bill which will incorporate a unified national health program with a national medical-care program. This bill must be available to present to the Diet not later than October 1, 1947. There are no individuals available in the War Department possessing the qualifications necessary to perform this assignment.

The War Department will reimburse the Federal Security Agency for the salaries, and other expenses incurred as a result of this detail, of Messrs. Mountin, Davis, and Sanders upon receipt of Standard Form 1080, supported by copies of the letters of agreement. Transportation expenses and a per diem allowance in lieu of subsistence will be paid by the War Department direct to Messrs. Mountin, Davis, and Sanders.

Sincerely yours,

KENNETH C. ROYALL,
Secretary of War.

FEDERAL SECURITY AGENCY,
Washington, August 13, 1947.

The Honorable KENNETH C. ROYALL,
Secretary of War, Washington 25, D. C.

MY DEAR MR. ROYALL: In answer to your request of August 6, the Federal Security Agency will make available to the War Department for a period of 60 days the services of Dr. Joseph W. Mountin and Dr. Burnet M. Davis, of the United States Public Health Service, and Mr. Barkev S. Sanders, of the Bureau of Research and Statistics, Social Security Administration.

Your request states that the services of Drs. Mountin and Davis and Mr. Sanders are desired by the Supreme Commander, Allied Powers in Tokyo, Japan, to participate in a Social Security and Insurance Mission for which qualified personnel are not available in the War Department. The objectives of the mission, as set forth in your letter, are to consult with public health and welfare and with the Japanese Committee on Social Insurance and Japanese Council on Medical Care in drafting a national health bill which will incorporate a unified national health program with a national medical-care program.

It is understood that Drs. Mountin and Davis and Mr. Sanders will undertake this assignment on or about August 28; that the War Department will reimburse the Federal Securit yAgency for the salaries and other expenses incurred as a result of this detail, and that transportation expenses and a per diem allowance in lieu of subsistence will be paid by the War Department direct to the three individuals assigned by this Agency.

Sincerely yours,

WATSON B. MILLER, *Administrator.*

SUMMARY OF AUGUST 26, 1947, CONFERENCE

This will sumarize the significant points discussed today with Dr. Mountin and Mr. Sanders preparatory to their departure for Tokyo, schedule on August 28, as Technical Consultants to assist in the drafting of a national health bill which will incorporate a unified national health insurance program with a national medical care program, as requested in the letter of the Secretary of War of August 6. Dr. Davis and Mr. Staten did not participate in this discussion because they were not in Washington. It was understood that while Drs. Mountin and Davis, Mr. Sanders and Mr. Staten are technical members of the Social Security Mission to Japan, they will function in Japan in accordance with the plans worked out by Mr. William Wandel, Chief, Social Security Division, SCAP, for the period during which the head of the mission is not in Japan. They will clear with the head of the mission their major technical recommendations before they are officially put forward.

In general their technical skills can be used most effectively as follows: Dr Mountin, the medical aspects involved in the organization and operation of health programs and institutions; Mr. Sanders, nonmedical aspects such as coverage, financial base and cash benefits, and their relationship to the other social-insurance programs; Dr. Davis, operating details and procedures for medical services; Mr. Staten, social insurance programs other than health and disability and their relationship to the health and disability programs.

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[1] Word "insurance" inadvertently omitted.

Pending the receipt of the report from the Social Security Division which will also include recomendations, plans with respect to other aspects of the mission are being held in abeyance. Attached for your information are copies of my letter to War Department of March 5, 1947, concerning the proposed Social Security Mission to Japan; excerpts from Mr. Cohen's letter to Mr. Wandel of August 4, 1947, containing information about the health and medical care part of the mission; and Secretary of War's letter of August 6, 1947, requesting the services of Dr. Mountin, Dr. Davis, and Mr. Sanders.

A. J. ALTMEYER.

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
Washington, D. C., August 4, 1947.

Mr. WILLIAM WANDEL,
General Headquarters, SCAP, Public Health and Welfare Section,
APO 500, care of Postmaster, San Francisco, Calif.

DEAR BILL: I hope that by this time you have received official notification through Major Simmons that we have been able to organize an "advance party" on health insurance which should arrive in Tokyo about September 1. When I left Washington on August 25, the tentative arrangements were that Dr. Joseph Mountin, Dr. Bernard Davis (now in London), and Barkev Sanders would come to deal specifically with health insurance and medical care. They would be part of the Social Security mission but would come ahead now because of your urgent needs.

I feel sure you will get some help by September 1. I also made arrangements for Ida Merriam to read, review, and send your report around for study so all of the staff would be in a position to help you wherever necessary.

If there is anybody or anything you want, be sure to let us know. I have assured Major Simmons that we will do everything humanely possible to help.

With best wishes to you and your staff, I am,

Sincerely yours,

WILBUR J. COHEN,
Technical Adviser to the Commissioner for Social Security.

P. S.—There will be no chief to the health part of the mission. Mr. Altmeyer is the chief of the Social Security mission and the three persons who are coming over now will act as your advisers and be part of the Social Security mission. I hope this is O. K. from your standpoint. It was on this basis that we were able to expedite clearance of these three persons for arrival on September 1. They should make some kind of report, therefore, for Mr. Altmeyer's use, too, in connection with the entire mission.

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
Washington, D. C., August 27, 1947.

Mr. WILLIAM H. WANDEL,
Public Health and Welfare, General Headquarters, SCAP,
APO 500, care of Postmaster, San Francisco, Calif.

DEAR BILL: I delayed answering your last letter, which reached me on August 18, until I could report specific information. Mr. Altmeyer has been back in the office this week, although beginning tomorrow he will be in New York for the second session of the United Nations Social Commission. Yesterday we worked in a conference with him, Dr. Mountin, and Mr. Sanders before their departure for Tokyo. A summary of that conference is enclosed for your information. This was checked with Major Simmons before it was released in order to be sure that it met the plans of the War Department.

Yesterday afternoon your materials, transmitted August 16, were received. Since the technicians on health insurance and medical care are scheduled to leave tomorrow morning, there has not been an opportunity for them to study these materials prior to departure, so we are arranging for them to take two copies of the material with them for review and study en route. At the same time, our staff people here will review these materials to furnish from your recommendation suggestions which Mr. Altmeyer and the War Department can consider regarding additional aspects of social security which may be worked on by mission personnel and decisions concerning what additional technical personnel can be made available. I notice you say that the body of your report will have been rounded out considerably by the time the mission personnel leaving tomorrow arrive in Tokyo. It will be most helpful to the people here concerned to have those materials forwarded promptly.

We are keeping in mind the suggestion of Mr. Neff that Helen Bary could give technical help in the general assistance program developmental work.

I should have mentioned above that Mr. Altmeyer has given to each of the technicians, before leaving tomorrow for Tokyo, the copy of the summary of the conference on August 26, so all of you will have the same information on these points.

Sincerely yours,

MAURINE MULLINER, *Executive Assistant.*

Release morning papers,
Wednesday, August 27, 1947

SUBCOMMITTEE ON PUBLICITY AND PROPAGANDA IN THE EXECUTIVE DEPARTMENTS

(Forest A. Harness, Chairman)

Representative Forest A. Harness, of Indiana, chairman of the Subcommittee on Publicity and Propaganda in the Executive Departments, today issued the following statement regarding the proposed health mission to Tokyo:

"It has come to the attention of our investigators that the Social Security Board and the United States Public Health Service jointly plant to send a special mission of Federal experts to Tokyo to advise and consult with Japanese authorities on a national health program for Japan. The mission is scheduled to leave for Japan about August 28.

"Our committee is informed that the proposed mission is composed chiefly of Federal employees now engaged in various phases of public-health and social-security administration in the United States, all of whom are known to be militant advocates of the Wagner-Murray-Dingell bill for compulsory health insurance in the United States. This program for socialized medicine has been urged four times in our own Congress and four times has been rejected in committee.

"Our information is that the proposed mission already has sent to Tokyo copies of the several versions of the Wagner-Murray-Dingell bill as introduced in Congress since 1939, together with voluminous hearings before the Senate Labor Committee presenting the views of the United States advocates of socialized medicine.

"Because the time is short, our committee has not had opportunity to complete its investigation of all the circumstances surrounding selection of this mission. But our preliminary inquiry has established that the project was conceived and arranged in the United States, chiefly by Federal employees within the Social Security Board and the United States Public Health Service.

"In preparation for the project, certain former employees of the Social Security Board were attached to the Public Health and Welfare Section of the occupation authority in Tokyo.

"Our committee has received and carefully studied the complete file of radio communications between Tokyo and Washington which laid the groundwork for the appointment of the health mission. No high-ranking occupation authorities figured in these arrangements.

"Our conclusion is that the demand for this mission did not originate in Japan, but among certain officials of the Secial Security Board in Washington.

"We are also convinced that the mission is committed in advance to a national program for socialized medicine in Japan.

"The evidence likewise is clear that the Wagner-Murray-Dingell bill already has been selected as the beginning point of the mission's health survey in Japan.

We feel that the nominal Japanese 'request' for such a mission was more a matter of departmental routine in Washington than a bona fide expression of Japan's needs and wishes in the matter of United States assistance in national health rehabilitation.

"Our inquiry discloses that one man selected by the Social Security Board to be a member of the Tokyo mission has returned only recently from a special assignment with the British Ministry of Health, in London, where he assisted in advancing a comprehensive program of socialized medicine through the British Parliament.

"As chairman of the subcommittee charged with investigating Government publicity and propaganda, I feel that this mission is a proper subject for public examination and discussion before it leaves Washington for Tokyo.

"We, therefore, present the matter for public consideration at this time, in the hope that some official action in the executive branch may delay departure of the mission until our investigation may be completed and all the facts presented to the Department of Justice.

"However concealed in official accounting procedures and interdepartmental transfers of funds and authorizations, such a use of Federal appropriations to advance the world program for socialized medicine appears to this committee to present a clear misapplication of Federal moneys far beyond any program or purpose ever within the intent of the Congress.

"Regardless of what action may be taken in the executive branch, it will be the firm purpose of this committee to complete its investigation of this matter and lay the complete picture before the Committees on Appropriations in the next Congress, and such other committees of the Congress as have these matters within their jurisdiction.

"Meanwhile, our investigation continues in the Bureau of Research and Statistics in the Social Security Board, where the scheme for a Japanese health mission originated."

Immediate release

WAR DEPARTMENT,
PUBLIC INFORMATION DIVISION,
PRESS SECTION,
August 27, 1947.

SOCIAL SECURITY MISSION DEPARTS FOR TOKYO THURSDAY

The War Department has announced the Thursday departure of a mission to Japan being sent at the request of Gen. Douglas MacArthur, Supreme Commander for the Allied Powers, to evaluate and to make recommendations regarding measures to achieve a sound social-security system for Japan.

Four advance members of the mission departing today by air are prominent health and welfare officials who, it is expected, will be joined at a later date by two other members, in addition to Mr. Arthur J. Altmeyer, Commissioner, Social Security Administration. They are: Dr. Joseph W. Mountin and Mr. Burnet M. Davis, of the United States Public Health Service; Mr. Barker S. Sanders, Social Security Administration; and Mr. Francis A. Staten, Public Housing Authority.

General MacArthur, last April, requested that Mr. Altmeyer be invited to head a six-man mission that would visit Japan in September for a period of 30 to 90 days. The mission will consult with Public Health and Welfare Section, SCAP, and will offer technical guidance to the Japanese Committee on Social Insurance and the Japanese Council on Medical Care, which are presently engaged in drafting a coordinated national health bill.

The Japanese workmen's compensation and seamen's insurance laws have been recently reformed, a child-welfare law is now pending, and a national health-insurance law, passed in 1926 and extended in 1942, covers approximately 42,000,000 Japanese. In March 1947 the Japanese Diet passed a resolution recommending the extension of the national health-insurance law.

Distribution: Aa, Af, B, Da, Dd, Dm, N.
7 p. m.

WAR DEPARTMENT,
CLASSIFIED MESSAGE CENTER,
August 31, 1947.

Incoming clear message—Priority
From: GHQ SCAP, Tokyo, Japan, signed MacArthur.
To: War for WDSCA.
Nr: Z 20007.

Reur War 85264.

There is no slightest concept at this headquarters of any socialization of medcine in Japan. The purpose of the mission from the United States is to advise with reference to the coordination and application of social-security measures which have been in practice in Japan for many years. In the aftermath of the war and the economic stringencies resulting therefrom the Japanese Government has found manifold difficulties in the implementation of its old health security laws. It appealed to this headquarters for advice and assistance in consolidation and simplification of existing codes in view of the general revision in governmental structure now taking place.

As the appropriate section of SCAP did not possess the expert ability called for, the United States Government's corresponding services were requested to lend competent personnel for a short period of time to consult with and advise in the premises. The individuals selected for this purpose are personally unknown to this headquarters but as responsible public officials of the United States Government must be presumed to be qualified. No socialization of medicine is at issue and nothing of propaganda is involved. The Japanese Government requested the advice and will be entirely free to accept it or not as it may wish. Its scope is not designed to initiate any concepts beyond present Japanese laws and will be limited merely to pass upon the adaptability, workability and practicability of those now existent.

Nothing new is planned beyond making old practices work. So far as this headquarters knows there has been no slightest effort or thought on the part of the United States Government services to inject themselves into the matter nor to impose any preconceived concepts or controversial issues such as the socialization of medicine on Japan, and their actions in making experts temporarily available represent nothing but healthy assistance in response to a normal request from a fellow governmental agency.

I suggest that the above facts be furnished those who protest this mission. I am sure the protests are caused by lack of accurate information in the matter.

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
Washington 25, D. C., December 11, 1947.

Maj. READ MORRISON,
Chief, Far East Section Personnel and Training Branch,
Civil Affairs Division, War Department,
Washington 25, D. C.

DEAR MAJOR MORRISON: On March 5, 1947, I wrote Maj. F. B. Simmons I had considered the proposal submitted by your office for a social security mission to Japan and that I should be glad to serve as the nominal head of the mission. On April 14, 1947, the Secretary of War wrote to the Federal Security Administrator requesting the services of William H. Wandel to serve as Chief of the Social Security Division, Public Health and Welfare Section of SCAP, which request was granted. On August 6 the Secretary of War wrote the Federal Security Administrator requesting the services of Dr. Joseph W. Mountin, Dr. Burnet M. Davis, both of the United States Public Health Service and Mr. Barkev S. Sanders of the Social Security Administration. This request was also granted. On August 26, as nominal head of the mission I furnished Dr. Mountin, Mr. Sanders, Dr. Davis, and Mr. Staten of the Public Housing Authority whose services had also been made available, a memorandum of instructions, copy of which is enclosed.

Messrs. Wandel, Sanders, Staten, and Drs. Mountin and Davis have now returned to the United States and. I am informed, submitted their reports prior to leaving Tokyo to Col. Crawford F. Sams, Chief of the Public Health and Welfare Section, SCAP, although I have not been furnished with a copy of any such reports. Under the circumstances I assume that these gentlemen have completed their mission and that any responsibility I may have had in the matter is now at an end. If my understanding is not correct I should appreciate your advising me.

If at any time we can be of assistance to you please let us know.

Sincerely yours,

A. J. Altmeyer, *Commissioner.*

Federal Security Agency,
Social Security Administration,
Washington 25, D. C., December 15, 1947.

Hon. Forest A. Harness,
House of Representatives, Washington, D. C.

Dear Congressman Harness: I have been informed by Mr. William H. Wandel, a former official of the Bureau of Employment Security of the Social Security Administration, Mr. Barkev S. Sanders, an official of the Bureau of Research and Statistics of the Social Security Administration, and Dr. Joseph W. Mountin, an official of the Bureau of State Services of the United States Public Health Service, that they have been requested to appear before your committee tomorrow morning at 10:30. It is the understanding of these gentlemen that you desire information relative to the social-security mission to Japan.

I, myself, have not yet been furnished with a formal report by these gentlemen, and I have not requested a report of them. It is my understanding that these gentlemen as regards their social-security mission to Japan are subject to the regulations of the Department of the Army.

However, both in my capacity as nominal head of the social-security mission and as acting Federal Security Administrator, I have informed these gentlemen that I desire to interpose no objection to your committee's having all the information which it may request.

Sincerely yours,

A. J. Altmeyer,
Acting Administrator.

War Department,
War Department Special Staff,
Personnel and Training Branch.
Washington 25, D. C., December 22, 1947.

Mr. A. J. Altmeyer,
Washington, D. C.

Dear Mr. Altmeyer: This will acknowledge your letter of December 11 with reference to the social-security mission which recently visited General MacArthur's headquarters in Tokyo.

We wish to thank you for your interest and close cooperation with this office in obtaining personnel to go to Tokyo on the social-security mission, and it was indeed unfortunate that you were not able to make the trip yourself.

We understand that the persons composing this special mission have completed their assignment and have made a report to General MacArthur's headquarters, and have now returned to this country to carry out their individual work.

We wish to again thank you for your interest in this mission, and we wish to advise you that your responsibility for the mission is now over, and should another mission of this type be requested by the Far East Command, we will again take the liberty to call upon you to assist us in selecting the personnel, and we hope that the next time you will be able to make the trip with the mission selected.

Sincerely yours,

Arthur W. Hodges, Jr.,
Lieutenant Colonel, GSC.,
Branch Executive.

Mr. Falk. I only have in mind, Senator, that I would not on my motion have thought that this episode with respect to the mission to Tokyo, which has received so much public discussion and attention in the press, in magazines, in medical journals—both State and local medical journals—I would not have supposed that it had any congressional bearing on bills before this committee, and I would not on my motion have undertaken to clutter your record with any of it. But since the matter has been brought up and used as an illustration of a charge that we have been engaged in some international plot to socialize medicine throughout the world, I thought that the committee might like to have as full and comprehensive a record of the facts as possible in order to let the facts speak for themselves and to indicate that this whole thing has been a lot of nonsense and foolery of some kind, which is very difficult for me to understand.

Senator DONNELL. The fact is, however, Mr. Falk, notwithstanding your views and notwithstanding the data that you submit, which may be quite correct, is it not a fact that Mr. Harness has not changed his position, as far as you know—publicly, at any rate—that he asserted in his letter of September 9, 1947?

Mr. FALK. That is correct, Senator, and when I say it is correct, it is correct so far as I know; and if it is correct, I think it is very unfortunate, and I hope very much that when the facts become available to Mr. Harness that he will change his position and that this episode will be closed and that all concerned, with good will, may forget a mistake that was made by somebody in following some bad leads.

Senator PEPPER. Excuse me, Dr. Falk. Do you know whether General MacArthur has changed any of his statements that he made which have been referred to? Has he changed any of his statements either?

Mr. FALK. I have no evidence of any kind that he has changed any of his, and I have been led to believe that he has reaffirmed them in other connections.

Senator PEPPER. Is it not rather difficult to understand why Mr. Harness has not made any correction of his statement unless he takes the position that General MacArthur is either not telling the truth or that General MacArthur does not know the facts? Have you ever heard any such inference or implication from Mr. Harness with respect to General MacArthur's statements?

Mr. FALK. Senator, I can only repeat what I have said before in substance. I am very much at a loss to understand this whole episode.

Senator PEPPER. As you know, I referred a few minutes ago to the Congressional Record of January 26, 1948, which contains this speech of Mr. Harness under date of October 24, 1947, and Mr. Harness himself, according to page A426 of the Congressional Record of January 26, 1948, says, in the House of Representatives, Monday, January 26, 1948, Mr. Harness of Indiana says the following:

> Mr. Speaker, I ask leave to extend my remarks in the record by including the following address delivered by me before the National Physicians and Surgeons Committee, Inc., Colorado Springs, Colo., on October 24, 1947.

Then he puts his own address in the record, without mentioning anything at the end of it to indicate that anything said therein has been contradicted by General MacArthur—in so many words.

It is rather difficult to understand why Mr. Harness would persist in making statements that he might have made inadvertently when they were first made in the face of the flat contradiction which has been made with respect to those statements, at least insofar as utterances by General MacArthur personally are concerned.

Senator Donnell. The record from which the Senator from Florida read, I understand, is yesterday's Record?

Senator Pepper. Yes.

Senator Donnell. That was placed in the Record by Mr. Harness yesterday?

Senator Pepper. Yes. He put his October 1947 address into the Record yesterday.

Senator Donnell. And so far as Mr. Falk knows, he has never revoked any of the statements contained in the letter of September 9.

Senator Pepper. So that the American jury may take the case on the testimony of Gen. Douglas MacArthur and Mr. Harness.

Senator Donnell. In addition, there is this article in the December 1947 edition of the Reader's Digest. I do not know when it was printed, but there is this article by Mr. Harness, which has been offered into the record.

Senator Pepper. Yes.

Senator Murray. May I make an inquiry?

Senator Donnell. Certainly.

Senator Murray. Would it be proper to infer that Mr. Harness may be a victim of this secret propaganda that was put out by Dr. Shearon, in which she claims to keep this all secret, originally claiming that she was the one who was inspiring this move by Mr. Harness, and that he may have been entirely deceived by the information that he has been receiving from that source?

Mr. Falk. Senator, I can only make these comments and still adhere to them; I can only adhere to that which I know, and for which I have a basis.

Mr. Harness, I believe, was misled in this matter, as he has been misled in some other matters relating to this subject. Now, maybe I am drawing an unfair, unjustified, and unwarranted inference, but it is a fact, I believe—these are facts, I believe.

The first intimation that there was something wrong about a mission going to Japan to assist General MacArthur, so far as I know, is the statement by Mrs. Shearon in her letter which you read for the record a little while ago.

Senator Murray. And she has been an adviser of this committee.

Mr. Falk. That may be so. I do not know.

The second point is that the investigator for the Harness committee, who came to us and has gone to other agencies of the Government for information on this matter, as on other matters, was Miss Hazel Huffman, who was identified by this committee, by Senator Donnell, in hearings held in 1947, as the reputed author of an anonymous article that appeared in Medical Economics, which I castigated and criticized as containing misinformation of all kinds concerning us and the Social Security Administration with respect to what has been happening in this health field.

Now, I do not know whether I am unwarranted in drawing the inference, but it is a fact that Mrs. Shearon's hand in this matter, apparently by her own statement, if that is a correct statement, precipitated this matter, and that Miss Hazel Huffman, who apparently has had some connections with Mrs. Shearon, was the staff investigator for the Harness committee in conducting this inquiry, or so much of it as I know about.

Now, I do think that I am justified and that I am warranted in drawing the conclusion which I expressed earlier, that Mr. Harness has not been well served. And may I add, I think the United States Government and General MacArthur and SCAP have not been well served.

Senator MURRAY. Do you think this committee has been well served by an agent who is registered as a lobbyist and who put out this sort of information to the American people? Do you think that this committee is getting good service from that source?

Mr. FALK. The only comment I can make on that, Senator Murray, is that it seems to me very unfortutnate that the time of this committee is spent on hearings like this instead of being spent on more constructive discussions with respect to the many bills now before Congress. I think a good deal of the committee's time has been taken up by this episode concerning the Japanese mission.

Senator PEPPER. Mr. Chairman, what seems to me more regrettable is the fact that whoever may be responsible for it—and I am not calling any names any place—but it is regrettable that this committee and all those who are trying to find the best way, everything considered, to make it possible for the American people to obtain the medical, hospital, and other services which they require—I think it is regrettable that an honest inquiry should be tainted and beclouded by charges and countercharges that impute to either one side or the other anything other than the highest motives and the purest American objectives in that pursuit.

If some of us happen to believe that a compulsory insurance system, where you pay something comparable to a social-security tax, is the best way that we know of by which the American people may obtain the hospital and medical service without which they are daily dying and suffering, we ought to be immune from the charge that we are in any way less possessed of American sentiments than anybody else; and others who happen to believe that another way is the best way to do it should be freed from the charge that they are careless of human life and indifferent to human suffering.

So I wonder when we are going to be able to lift the whole inquiry out of the contamination of these innuendoes and get it up to a level where we are trying to discuss what is the best way, everything considered, to make it possible for the American people to save their lives and their health, by paying the medical and other services that they happen to require.

Senator DONNELL. Mr. Cohen, I would like to ask you whether or not you and Major Simmons and Miss Mulliner caused to be sent to Col. Crawford F. Sams, Chief, PHW; Mr. William Wandel, Chief, Social Security Division; Mr. George Pollock, Deputy Chief, Social Security Division; Mr. George Rohrlich, Chief, Economics Analysis Branch; and Mrs. Leone M. Moor, personnel coordinator, PHW; a series of cablegraphic communications, if I may term them that, starting with WD 1 and continuing on down through WD 11, sometime in July of 1947?

Mr. COHEN. Senator, let me see. I was the person responsible for the messages in part sent from Washington to Tokyo in the teleconference of July 17, 1947.

Senator DONNELL. Is it July 17? It is impossible to tell from the copy I have here.

Mr. COHEN. That is my understanding.

Senator DONNELL. All right.

Mr. COHEN. And I would like to say, Senator, in this connection, that I was the person who was largely responsible for carrying on the negotiations with respect to this mission requested by General MacArthur, and that I would be glad to go into detail; but I would like to say that Mr. Falk, despite what is said in all of these messages and charges and countercharges, had no substantial participation whatsoever in suggesting the mission, the names of the persons, the content of the mission, their duties, or anything whatsoever. The discussions, if you would like to hear about them, were originated with a representative of SCAP, Mr. Stanchfield, who, we were led to believe, had full powers from Tokyo, who came here and talked with Mr. Altmeyer, and at Mr. Altmeyer's request I continued the discussions with Mr. Stanchfield.

I believe it is fair to say that, outside of some conversations which I believe Mr. Stanchfield had with Mr. Falk, in no way was Mr. Falk responsible for any of the major decisions taken with respect to this activity; and the charges and statements about Mr. Falk and his participation in it, in my opinion, are untrue and unfounded.

Senator DONNELL. Mr. Cohen, however, you did, in conjunction with Major Simmons and Miss Mulliner, cause to be sent this teleconference of July 17, 1947; is that correct?

Mr. COHEN. Yes, sir.

Senator DONNELL. I would like to read that into this record, if you please. Do you have a copy of it before you so that you may follow it?

Mr. COHEN. No; I do not, Senator.

Senator DONNELL. I will read it correctly. I will read this series.

WD-1. *For Wandel.*

Mr. Altmeyer has not yet returned from Europe and departure of social-security mission may be delayed. Mr. Cohen is leaving town in a few days for an extended period; so it is deemed essential, now that you have had the opportunity to review the situation, to learn your desires concerning the composition of the mission before Mr. Cohen leaves.

End of item.

WD-2. *For Rohrlich.*

Mr. Bishop has left Social Security and has another position in New York, Mr. Sanders states Bishop will probably not be interested in economic analyst spot. Dr. Falk and Mr. Sanders have promised to assist in every way possible to get qualified man for you. Do you have any suggestions you want us to consider?

End of item.

WD-3. *For Janis.*

A Miss Hapney has indicated you may desire her services and has left form 57. She appears capable, but would not qualify for more than a P-2 rating.

End of item.

WD-4. *For Wandel.*

We have a letter from Francis A. Staten. Mr. Cohen thinks him very capable. Believe he has written you. Do you wish us to take any action in connection with him?

End of item.

WD-5.

We would like to obtain further information from SCAP in order to begin our planning for the social security mission. Altmeyer will probably not return from Europe before the end of August or early September, and pending business here makes it impossible to say now what his schedule will be. In order that he may make his plans when he returns, we should like to have a recommendation from you as to when the best time or times would be for the mission to arrive, what emphasis should be given in selecting personnel for the mission, how many persons should be in the mission, what specifically the mission would do, how long it would stay, and what materials could be sent to members of the mission before it departs? Could you give us now some indication of your suggestions on these matters and follow them up with a detailed memorandum specifically outlining your recommendations on these and any related points. Do you have any suggestions you want us to consider?

End of item.

WD-6.

From the tempo of your letters it appears that health insurance is now your primary problem. If you deem it important enough every effort will be made to get Dr. Perrott and one or two others in this field on the mission.

End of item.

WD-7.

Reur item 3.

Since mission may arrive at time Wandel is about to return we believe it is desirable to consider Staten as replacement and possibly to accompany mission.

End of item.

WD-8.

Reur item 4.

We will then plan on mission to be composed of Dr. Perrott (if possible) and other health insurance men. Mission will arrive by September 1. Will plan on Mr. Altmeyer coming at later date. Will cable names of members and request approval as soon as available.

What will social security division report contain? Will it cover all aspects of social security or only health insurance and medical care? Please forward five copies of report by air mail by first week of August, if possible, in order to assist in interesting right people to participate in mission.

End of item.

Senator DONNELL. I interpolate this as Mr. Perrott. He is not a doctor, is he?

Mr. COHEN. Yes, sir.

Senator DONNELL. Continuing with the next item:

WD-9.

Reur item 4.

What would your reaction be to following individuals for work on health insurance: Sanders, Klem, or Louis Reed. Do you have any other suggestions?

End of item.

WD-10.

On basis this telecon will then get health insurance part of mission under way by September 1 and follow as soon as possible with rest of mission according to need indicated by your report and recommendations.

End of item.

WD-11.

Reur item 8.

Will consider Mountin. Will discuss with Surgeon General Parran.

End of item.

Mr. COHEN. Senator, may I ask you a question there?

Senator DONNELL. Yes.

Mr. Cohen. You are just reading now the communications that went from Washington to Tokyo?

Senator Donnell. That is right, and then I have the answer, which I wanted to read in a moment also.

Mr. Cohen. Yes, but the point that I was going to make, Senator, is I think it would be clearer if each of these inquiries, as they went along, were shown as in response to a reply from Tokyo. Those numbers that you read, in other words, were not a consecutive series but constitute an exchange of views. Some of the statements made from Washington are only understandable when you know what it is that the comment or the inquiry or the question was as it came from Tokyo.

Senator Donnell. I do not have it.

Mr. Cohen. It probably is all in there, but I say for the record that it would not be very understandable to know how you got from A to Z, without knowing in between what it was that Tokyo and the representatives of SCAP were asking us for our comments on, because those were not comments which were gratuitous, but which were in reply to the request of SCAP for information.

Senator Donnell. If there is any portion of the other correspondence that you think should be admissible, Mr. Cohen, I have it here. You are perfectly at liberty to put it into the record. The portion that I have read, so far as I know, is the material part of what you have said.

Mr. Cohen. Yes.

Senator Donnell. And I do not know of anything further that you said which is material. If there is any part regarding what led up to it that you think should be admitted, I would be very happy to hand you the complete file so that you may incorporate it into the record. I think the portion that I read is understandable.

Mr. Cohen. The conversation is by your sending the message and then you wait for approximately 2 or 3 minutes until a reply comes in on the telecon and it is flashed on the screen for you to read, and then when that communication comes in you reply with your second communication. So that is the way the flow of the conversation went, and I think it is extremely important in establishing the points.

Senator Donnell. I think Mr. Cohen's position is well taken, Mr. Chairman.

Senator Smith. I was going to suggest that Mr. Cohen might state this consecutively in the record. I agree with you that it is utterly meaningless this way.

Mr. Cohen. You are reading answers to a statement that you do not have the questions for.

Senator Donnell. I agree with you, Mr. Cohen, and if agreeable to you I am going to hand this to you, and we will have the reporter put in everything that is in this record. Of course, the portions I have read and your answers are understandable, but I think your point is well taken, and this may be incorporated in the record. It is somewhat bulky here but it will probably not consume much in actual type. I want to read, however, with the understanding that you may put everything else in the record—I am going to read into the record this one item from Colonel Sams, Mr. Wandel, Mr. Pollock, Mr. Rohrlich, and Mrs. Moor [reading FEC item 4 (reference item 5)]:

> Urgent that mission arrive not later than September 1, even if Mr. Altmeyer cannot accompany mission at that time. Desire mission for 60 days. Purpose of mission to be to consult with PH and W and with Japanese Committee on Social Insurance and Japanese Council on Medical Care, for purpose of drafting a national health bill which will incorporate a unified national health-insurance program with a national medical-care program. This bill must be available to present to Diet not later than October 1. Do deem it important to get Dr. Perrott and others familiar in this field, together with Mr. Cohen. Japanese groups continuing studies. Report by Social Security Division should be completed shortly after August 1 and can be sent to Cohen.

Now, Mr. Cohen, I think, if it meets the chairman's approval, we might suspend at this point—that is, my examination at any rate—and I would like to have you—I will hand this to the stenographer with the understanding that he may take everything in here, this whole file, and put it in chronological order and place it in the record.

Mr. COHEN. Before you adjourn, Mr. Chairman, may I have just a moment?

Senator DONNELL. Pardon me, Senator, so the record will show that this entire file which I now hand to the reporter will go into evidence, with the understanding that it will be incorporated chronologically, in accordance with the suggestion of Mr. Cohen, which I think is a proper suggestion.

Mr. COHEN. Pardon me just one moment, Senator. Do you wish to interrogate me further on that? Because I would like to comment on those statements.

Senator DONNELL. I think it is fair that you should have that right, and I would suggest, Mr. Chairman, that at the beginning of our next hearing, which I think will be day after tomorrow, Mr. Cohen be given the opportunity of making any and all comments he may desire with respect to this matter.

Senator SMITH. Very well.

(There follows the record of the teleconference between Washington, D. C., and Tokyo, Japan, July 17, 1948 (chronological file referred to). Messages sent from Washington are identified by the symbol "WD" and messages sent from Tokyo are identified by the symbol "FEC".)

Teleconference—July 17—TT 8337.

Present here (i. e. Washington, D. C.): Maj. F. B. Simmons: CAD; Mr. Wilbur J. Cohen: Soc. Sec.; Miss M. Mulliner: Soc. Sec.

Subject: Social Security mission.
Classification: Unclassified.
WD–1. For Wandel.

Mr. Altmeyer has not yet returned from Europe and departure of Social Security mission may be delayed. Mr. Cohen is leaving town in a few days for an extended period; so it is deemed essential, now that you have had the opportunity to review the situation, to learn your desires concerning the composition of the mission before Mr. Cohen leaves.

(End of item.)

WD–2. For Rohrlich.

Mr. Bishop has left Social Security and has another position in New York. Mr. Sanders states Bishop will probably not be interested in economic analyist spot. Dr. Falk and Mr. Sanders have promised to assist in every way possible to get qualified man for you. Do you have any suggestions you want us to consider?

(End of item.)

Teleconference—WCR V TKG—July 18.
Present here (i. e. Tokyo, Japan) : Col. Crawford F. Sams, Chief, PHW ; Mr. Wm. Wandel, Chief, Soc. Sec. Div. ; Mr. Geo. Pollock, Deputy Chief, Soc. Sec. Div. ; Mr. Geo. Rohrlich, Chief Econ. Ananysis Br. ; Mrs. Leone M. Moor, Personnel. Coordinator, PHW.
Subject : Social Security mission.
Classification : Unclassified.

FEC item 1. Ref. item 2.

Suggest further contacts with BLS personnel and Bishop and forward 57's of those interested and available.
(End of item.)

FEC item 5. Further Ref. item 2.

Bob Guyol, of office of intelligence research, Department of State, might have candidate. Refer to my telephone conversation with him mid-June.
(End of item.)

WD–3. For Janis.

A Miss Hapney has indicated you may desire her services and has left Form 57. She appears capable, but would not qualify for more than a P–2 rating.
(End of item.)

FEC item 2. Ref. item 3.

Believe Miss Hapney would be useful assistant. Job in process of being established. Will advise by radio when job available.
(End of item.)

WD–4. For Wandel.

We have a letter from Francis A. Staten. Mr. Cohen thinks him very capable. Believe he has written you. Do you wish us to take any action in connection with him. (End of item.)

FEC item 3. Ref. item 4.

Suggest no action pending discussion with Altmeyer after arrival of mission.
(End of item.)

WD–5.

We would like to obtain further information from SCAP in order to begin our planning for the Social Security mission. Altmeyer will probably not return from Europe before the end of August or early September, and pending business here makes it impossible to say now what his schedule will be. In order that he may make his plans when he returns, we should like to have a recommendation from you as to when the best time or times would be for the mission to arrive, what emphasis should be given in selecting personnel for the mission, how many persons should be in the mission, what specifically the mission would do, how long it would stay, and what materials could be sent to members of the mission before it departs? Could you give us now some indication of your suggestions on these matters and follow them up with a detailed memorandum specifically outlining your recommendations on these and any related points.

Do you have any suggestions you want us to consider?
(End of item.)

FEC item 4. Reference item 5.

Urgent that mission arrive not later than September 1, even if Mr. Altmeyer cannot accompany mission at that time. Desire mission for 60 days and purpose of mission to be to consult with P. H. and W. and with Japanese Committee on Social Insurance and Japanese Council on Medical Care for purpose for drafting a national health bill which will incorporate a unified national health-insurance program with a national medical-care program. This bill must be vailable to present to diet not later than October 1. Do deem it important to get Dr. Perrott and others familiar in this field together with Mr. Cohen. Japanese groups continuing studies. Report by Social Security Division should be completed shortly after August 1 and can be sent to Cohen.
(End of item.)

WD 6.

From the tempo of your letters it appears that health insurance is now your primary problem. If you deem it important enough every effort will be made to get Dr. Perrott and one or two others in this field on the mission.

(End of item.)

WD 10.

On basis this Telecon will then get health insurance part of mission under way by September 1 and follow as soon as possible with rest of mission according to need indicated by your report and recommendations.

(End of item.)

WD 7.

Reur item 3.

Since mission may arrive at time Wandel is about to return we believe it is desirable to consider Staten as replacement and possibly to accompany mission.

(End of item.)

FEC item 6. Ref. item 7.

Would agree to having Staten included in mission. Any other potential successors to Wandel should also accompany mission.

(End of item.)

WD 8.

Reur item 4.

We will then plan on mission to be composed of Dr. Perrott (if possible) and other health insurance men. Mission will arrive by September 1. Will plan on Mr. Altmeyer coming at later date. Will cable names of members and request approval as soon as available.

What will Social Security Division report contain? Will it cover all aspects of social security or only health insurance and medical care? Please forward five copies of report by air mail by first week August, if possible, in order to assist in interesting right people to participate in mission.

(End of item.)

FEC item 7.

Reur item 8.

SS report will cover up-to-date review of all existing social-security programs, major problems, and tentative recommendations. Anticipate that recommendations will cover all social insurances and relations with other forms of social security.

(End of item.)

WD 9.

Reur item 4.

What would your reaction be to following individuals for work on health insurance: Sanders, Klem, or Louis Reed? Do you have any other suggestions?

(End of item.)

FEC item 8. Ref. item 9.

Reaction favorable to Sanders, Klem, and Reed. No other suggestions at moment. Mountin previously suggested by Janis.

(End of item.)

WD 11.

Reur item 8.

Will consider Mountin. Will discuss with Surgeon General Parran.

(End of item.)

Senator PEPPER. Mr. Chairman, apropos of my comment a moment ago that honest men may approve this subject of providing necessary medical and hospital care for the people, though differing in methods, with equal honesty and patriotism, I want to call attention to five bills and ask that they be incorporated in the record of these hearings, because they are part of the literature on this subject.

The first bill is S. 855, introduced in the Senate on the 15th of January 1937 by Senator Capper, of Kansas, a bill to aid in alleviating the loss caused by sickness.

The second bill is S. 3660, introduced in the Senate on the 25th of March 1940 by Senator Capper, of Kansas, entitled "A bill to aid in the establishment and administration of State health insurance plans."

The third is S. 489, introduced in the Senate January 23, 1941, by Senator Capper, of Kansas, to aid in the establishment and administration of State health insurance plans, on page 2 of which appears the following provisions:

> ### State Plans for Health Insurance
>
> Sec. 1202. A State plan for health insurance shall be approved only when the Board finds that it complies with the conditions, standards, and provisions contained in this section, as follows:
>
> (a) Premiums: (1) The fund out of which benefits are paid is created and maintained by regular premiums thereto paid by the State, employers, and employees set according to the wage clauses and equal to at least the weekly rates for each calendar week or any part thereof contained in the following schedule—

and the schedule appears here.

Senator Smith. Do I understand that the Senator wants the full text of these bills incorporated in the record?

Senator Pepper. That is right, as part of the history of this legislation.

Senator Smith. You have them all together there?

Senator Pepper. Yes.

Senator Smith. The Senator does not contemplate that anybody is going to read all these bills through at this late date, does he, unless the reader has a bedtime inclination that most of them do not have?

Senator Pepper. I want the record of this legislation, Senator, as I am sure we all do.

Senator Smith. I am a little dismayed at the size of them, but I agree with the Senator that we want a complete record, and we will put them in as the Senator requests.

Senator Pepper. There are two more, Mr. Chairman, S. 2963, introduced in the Senate on August 4, 1939, by Senator Lodge, of Massachusetts, a bill to provide health insurance to certain workers in severe economic distress.

The last one is H. R. 9847, introduced in the House of Representatives March 14, 1938, by Mr. Treadway, of Massachusetts, a bill providing for the establishment of a national system of health insurance.

By examining those bills we will see that many other able and patriotic Americans have approached this subject in the manner as indicated in those bills.

Senator Smith. And as the Senator has noted, it is quite proper to observe that there are a few Republicans who have fathered measures of this character.

Senator Pepper. And I am sure that their colleagues would not wish to charge these patriotic Americans with fomenting socialistic medicine or communism. Thank you, Mr. Chairman.

Senator Smith. The committee will recess until Thursday morning at 10 o'clock, and Mr. Cohen will be here at that time.

Senator MURRAY. And Mr. Falk will be here, too, I presume?

Senator SMITH. Yes, Mr. Falk will be here also.

(The exchange of telegrams with the exception of telecons previously inserted, as submitted by Senator Donnell, is as follows:)

War V TKG NR 534 Routine.
From: SCAP 110401Z.
To: Washington (WDSCA).
GREST 224.

Paren Z 42338 paren preference our telecon one four March one nine four seven dash tare tare seven eight seven zero it is requested that an invitation be extended to Mister Arthur Jig Altmeyer CMA Commissioner CMA Social Security Administration to head able mission of six people to visit Japan for able period of thirty to ninety days effective on or about one September one nine four seven to evaluate and to make recommendations regarding measures to achieve able sound Social Security System for Japan PD it is recommended that the following individuals be included in the mission CMA Mister Wilbur Cohen CMA Mister Item Sugar Falk CMA Doctor George Perrott CMA Doctor Oscar Vigert and Doctor Tillman Sogge PD

BT 110401Z.
0404Z.

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
OFFICE OF THE COMMISSIONER,
Washington 25, D. C., March 5, 1947.

Maj. F. B. SIMMONS,
Personnel and Training Branch, Civil Affairs Division,
War Department, Washington 25, D. C.

DEAR MAJOR SIMMONS: This is to indicate my reaction to the arrangements proposed by your office, through Mr. Stanchfield, for a social security mission to Japan.

As I understand it, the purpose of the mission would be to assist SCAP in evaluating social security programs now in existence in Japan and to advise SCAP regarding pending or proposed measures to achieve a permanent sound social securtiy system for that country.

I should be glad to serve as nominal head of the mission and would hope that I could spend at least a month in Japan, probably during late August and September. I would be accompanied by Mr. Wilbur J. Cohen, the Assistant Director of Research and Statistics of the Social Security Administration.

I would want Mr. William H. Wandel, Chief of the Program Division, Bureau of Employment Security, to serve on the mission. In order to do necessary preparatory work, he should precede us to Japan by about 3 months and should remain for about 3 months after our visit in order to finish up any necessary details.

I should think it advisable, and would recommend, that while in Japan on the mission, Mr. Wandel also serve as Chief, Social Insurance Division, Public Health and Welfare Section, Staff of the Supreme Commander. If such an arrangement can be made I believe it would greatly facilitate the preparatory background work to be done and add to the success of the mission.

I would recommend that there be included in the mission a person specially qualified on public welfare to cover the field of assistance, relief, and family and child welfare services.

I would also recommend that Mr. Anton and Dr. Lee Janis be included in the mission and that, insofar as possible, the services of Mr. Stanchfield be made available to the mission.

I am leaving next week to go to Geneva, Switzerland, as Executive Secretary of the Preparatory Commission for the International Refugee Organization. I shall return to Washington about August 1. In the meantime, if you desire that the Social Security Administration help you in any way, either along the lines outlined above or in some other manner, please get in touch with Mr. Wilbur J. Cohen (National War Agencies, extension 3377).

Sincerely yours,

A. J. ALTMEYER, *Commissioner.*

GENERAL HEADQUARTERS,
SUPREME COMMANDER FOR THE ALLIED POWERS,
PUBLIC HEALTH AND WELFARE SECTION,
SOCIAL SECURITY DIVISION,
June 14, 1947.

Dr. I. S. FALK,
Director, Bureau of Research and Statistics,
Social Security Administration, Federal Security Agency,
Washington, D. C.

DEAR MR. FALK: We are still recruiting for vacancies in the Social Security Division of the Public Health and Welfare Section. Yesterday we thought all vacancies filled; today we know that a person who was to fill a position of economic analyst will not be able to come. Our organization of the Division follows this pattern:

Chief: William H. Wandel.
Deputy Chief: George F. Pollock.
Branches:
  Social Insurance (other than Health Insurance: L. R. Anton and P. Sullivan.
  Health Insurance: L. Janis.
  Economic Analysis: G. L. Rohrlich. (Vacancy CAF–12)

We now think that our need is for someone who is primarily not so much an economic analyst as one versed in health insurance. Health insurance is the major field of social security in Japan. Existing problems are both of an emergency character and of permanent reformulation of the program. The emergency is due to the critical condition of the voluntary National Health Insurance Associations, the financial resources of which have not kept pace with the increased costs of medical service. Permanent revision requires amalgamating national health insurance with health insurance, on a compulsory basis. In view of the magnitude of the job and the amount of field work necessary to gain an understanding of these systems, Dr. Janis needs assistance. While the need for this job should and probably will be recognized by the establishment of a new position, we are not planning now to take the time necessary to write up a new job description and set up a new vacancy. Rather, we wish to fill the existing vacancy with someone who can properly fill it, but who also will be qualified to give special attention to the problems in health insurance.

I believe that special consideration is being given this Division to permit us to recruit for a contract period of 1 year rather than for the standard 2 years.

I hope you can recommend someone for this job. I would be glad to know of your recommendations, but do not think you should hesitate to suggest to anyone you would recommend that he get in direct touch with Maj. Franklin B. Simmons, Civil Affairs Division, War Department, room 3B859, Pentagon Building, extension 3445. (I am sending a copy of this letter to him and to Wilbur Cohen.)

I find the work here very interesting and engrossing. One is reminded forcibly of the apparently universal character of the conflict of established interests, but nevertheless there are real possibilities for accomplishment. I am glad I came out.

Sincerely,

WILLIAM H. WANDEL, *Chief.*

GENERAL HEADQUARTERS,
SUPREME COMMANDER FOR THE ALLIED POWERS,
PUBLIC HEALTH AND WELFARE SECTION,
SOCIAL SECURITY DIVISION,
July 1, 1947.

Mr. B. SANDERS,
Chief, Health and Disability Studies,
Bureau of Research and Statistics,
Social Security Administration,
Washington 25, D. C.

DEAR MR. SANDERS: When I came to see you in your office a few weeks ago, just prior to my departure from Washington, you mentioned the fact that due to budget cuts in Congress you were forced to let go your assistant, Mr. Bishop. I wonder if Mr. Bishop might not be interested in an opening in our Social Security Division of SCAP. The job is rated as a P–5, economic analyst, and pays the usual 25 percent additional overseas allowance.

While Mr. Bishop's position would be located in the Economic Analysis Branch, I should be very glad to give him every opportunity to work primarily on problems of health insurance, in close cooperation with Dr. Lee Janis, Chief of the Health Insurance Branch, who is at present the only person dealing with this, probably the most important of all Japanese social-insurance programs. Thus Mr. Bishop would be working in his special field where his contribution would be most welcome, I assure you, and where the need for help is greatest at this time. Besides, our set-up here is very informal and not at all compartmentalized.

If Mr. Bishop is no longer with you I would appreciate it greatly if you will forward this letter to him, as I do not have his address. In fact, I do not have the pleasure of knowing Mr. Bishop personally, but I know of him and his work. Doctors Wandel and Janis, likewise, extend their cordial invitation to Mr. Bishop to join us here at his early convenience. He may wish to write me directly. In any case, I would urge him to also get in touch with Major Simmons, or his successor, at 3B859 Pentagon, Republic 6700, extension 3445, who will be glad to give him all the information pertaining to the job and start processing him if he is willing to accept it.

Many thanks for this bother, and kind regards from us all.

Yours sincerely,

George F. Rohrlich,
Chief, Economic Analysis Branch.

WDSCA/3445
Maj. Simmons/mjr

Personnel and Training Branch,

WDSCA 231.2 *August 5, 1947.*

Memorandum to Administrative Assistant to the Secretary of War.

(Attention: Miss Sellers, Room 3C856.)

Subject: Request for Services of Individuals on Reimbursable Loan Basis.

1. Request necessary action be taken to secure the services of the following individuals on a reimbursable basis for a period of approximately 60 days beginning on or about August 28, 1947.

(*a*) Joseph W. Mountin, Associate Chief, Bureau of State Services, USPHS, grade, Assistant Surgeon General, $9,211 per annum.

(*b*) Burnet M. Davis, surgeon, USPHS, $5,821.50 per annum.

(*c*) Barker S. Sanders, Chief, Health Studies Division, Bureau of Research and Statistics, Social Security Administration, grade, P–6, $7,820.40 per annum.

2. SCAP has requested the services of the above individuals to participate in a social security and insurance mission, the objectives of which are as follows:

> "To consult with Public Health and Welfare and with Japanese Committee on Social Insurance and Japanese Council on Medical Care for purpose of drafting a national health bill which will incorporate a unified national health-insurance program with a national medical-care program. This bill must be ailable to present to Diet not later than October 1."

3. There are no individuals available in the War Department possessing the qualifications necessary to perform this assignment.

4. Request that Federal Security Agency be asked to submit copies of letters concerning this reimbursable detail; agreement be submitted when Forms 1080 are presented for payment.

For the Chief, Civil Affairs Division:

Arthur W. Hodges, Jr.,
Lieutenant Colonel, General Staff Corps,
Branch Executive.

WDOAP x5378
HAS/mg
AUGUST 6, 1947.

Mr. WATSON B. MILLER,
Administrator, Federal Security Agency,
Washington 25, D. C.

DEAR MR. ADMINISTRATOR: It is requested that the services of Mr. Joseph W. Mountin, Medical Director, $9,211 per annum, Mr. Burnet M. Davis, surgeon, $5,821.50 per annum, both of the United States Public Health Service, and Mr. Barker S. Sanders, Chief, Health Studies Division, Bureau of Research and Statistics, $7,820.40 per annum, of the Social Security Administration, be made available to the War Department for a period of approximately 60 days, beginning on or about August 28, 1947, on a reimbursable basis.

The Services of Messrs. Mountin, Davis, and Sanders are desired by the Supreme Commander, Allied Powers in Tokyo, Japan, to participate in a social security and insurance mission, the objectives of which are to consult with Public Health and Welfare and with the Japanese Committee on Social Insurance and Japanese Council on medical care for the purpose of drafting a national health bill which will incorporate a unified national health program with a national medical care program. This bill must be available to present to the Diet not later than October 1, 1947. There are no individuals available in the War Department possessing the qualifications necessary to perform this assignment.

The War Department will reimburse the Federal Security Agency for the salaries, and other expenses incurred as a result of this detail of Messrs. Mountin, Davis, and Sanders upon receipt of Standard Form 1080, supported by copies of the letters of agreement. Transportation expenses and a per diem allowance in lieu of subsistence will be paid by the War Department direct to Messrs. Mountin, Davis and Sanders.

Sincerely yours,

KENNETH C. ROYALL,
Secretary of War.

cc: Coord. & Records, OSW.
Civil Affairs Div.
Corres. File, Rm 3C856.
Asst. Adm. Asst.

WAR DEPARTMENT

CLASSIFIED MESSAGE CENTER

Outgoing Clear Message

War Dept., Washington, D. C.
Major Simmons 445
AUGUST 9, 1947.

CINCFE, Tokyo, Japan.
Number: WCL 41874.
From: WDSCA PT. Reurad April Z 42338 and July WDTT 8337.

Following individuals have been selected as members of social security missions:

Jos. W. Mountin, Associate Chief, Bureau State Services, USPHS.
Burnet M. Davis, surgeon, USPHS.
Barker S. Sanders, Chief, Health Studies Division, Bureau Research and Statistics, Social Security Administration.
Frances A. Staten, assistant regional director for management, FPHA.

ETD August 28. Please furnish highest APR and authorized 35 pounds excess baggage soonest.

Commissioner Altmeyer, Mr. Wilbur Cohen, and remainder of mission will depart at later date.

Please forward copies of Social Security report to WDSCA PT soonest.

Originator: CAD.
Distribution: OSW/CPD.
MC Out 41874 (Aug. 47) DTG 091850Z sej.
Unclassified.

WDSCA/3445
Major Simmons/cr
Unclassified
Routine
War Department,
Washington, D. C., August 11, 1947.

To: Dr. Burnet M. Davis, Ministry of Health, Whitehall, London SW–1, England.
From: Civil Affairs Division.

Reference your assignment on mission to Japan. Army authorities, Frankfurt, Germany, will arrange your air travel Stateside. Arrival here August 25.

Memo for record:

By MC IN 54264, April 11, SCAP requested the services of Commissioner Altmeyer, Social Security Administration, and five or six additional individuals to compose a social security insurance misson to Japan. This matter was further discussed in TT 8337, July 17, and theater was advised at that time that Mr. Altmeyer would not be available until the end of September. Due to the urgency of getting experts in theater on health insurance, it was decided to send four members of the mission who are experts in health insurance to the theater prior to the departure of Commissioner Altmeyer. Dr. Davis, who has been made available by the United States Public Health Service, is presently stationed in London, England, with the Ministry of Health of the British Government, and has the most up-to-date information on the problems of health insurance. This cable is being dispatched to advise Mr. Davis how arrangements will be made for his transportation to the States. He has been alerted by USPHS for this assignment. FBS.

C. R. Smith,
Major, AGD,
Administrative Officer.

Unclassified.

WDSCA Major Simmons/3445.

August 13, 1947.

To: Col. S. T. Williams, Branch Chief, P. and T. Branch, CAD.
From: Maj. F. B. Simmons, Jr.
Subject: Social Security and Insurance Mission

1. In telecon 7870, March 14, 1947, the Public Health and Welfare Section, SCAP, made tentative arrangements for a social security and insurance mission to be sent to Japan. Arrangements made in this telecon were firmed up in MC IH 54264, April 11, and it was requested that an invitation be extended to Commissioner A. J. Altmeyer, of the Social Security Administration, to head a mission of about six people to come to Japan about September 1 for 30 to 90 days.

2. In telecon 8337, final details as to the make-up of the mission were discussed and Public Health and Welfare Section, SCAP, stated their greatest need was for personnel who were experts in health insurance. On the basis of this telecon, it was decided that the mission would include available experts from the United States Public Health Service and Social Security Administration in health insurance. This personnel would arrive in Japan, and Commissioner Altmeyer and remainder of mission would depart at a later date.

3. On August 5 we sent a memorandum to Secretary of War's office requesting a letter be dispatched to Federal Security Agency to secure services on reimbursable detail of two individuals from USPHS and one from Social Security Administration. The requested letter was signed August 6 by the Secretary and was hand-carried to Federal Security Agency by myself.

4. Yesterday Miss Mulliner, who is Acting Commissioner of the Social Security Administration in Mr. Altmeyer's absence, advised me that Congressman Harness, chairman of a subcommittee of the House Committee on Expenditures in the Executive Departments, has taken an interest in the matter and has requested a copy of the Secretary's letter to the Federal Security Administrator. Miss Mulliner has furnished the letter. Miss Mulliner states Representative Harness takes a dim view of foreign travel of Federal employees and is dead set against anything which sounds like socialized medicine in any form and that the matter will likely be investigated further.

F. B. Simmons, Jr.,
Major, General Staff Corps,
Far Eastern Section.

Memo for record:

In MC IN 54264, April 11, SCAP requested the services of Commissioner Altmeyer, Social Security Administrator, and five or six additional individuals, to compose a social security insurance mission to Japan. This matter was further discussed in TT 8337, July 17, and theater was advised at that time that Mr. Altmeyer would not be available until the end of September. Due to the urgency of getting experts in the theater on health insurance, it was decided to send four members of the mission who are experts in health insurance to the theater prior to the departure of Commissioner Altmeyer. Above memo is being written to administrative assistant to OSW to secure necessary letter to be signed by the Secretary of War to Federal Security Administrator to get three individuals as members of the mission on reimbursable detail. FBS.

Telecon—14 0100Z MAR TT 7870.

Present here i. e., Washington, D. C.: Maj. F. B. Simmons, CAD.

Subject: Personnel for Social Security and Insurance Div. PH & WS and 406th Med Gen'l Lab.

Classification: Unclassified.

WD-1.

Following letter received by Major Simmons from Commissioner Altmeyer of Social Security Administration.

"This is to indicate my reaction to the arrangements proposed by your office, through Mr. Stanchfield, for a social security mission to Japan.

"As I understand it, the purpose of the mission would be to assist SCAP in evaluating social-security programs now in existence in Japan and to advise SCAP regarding pending or proposed measures to achieve a permanent sound social-security system for that country.

"I should be glad to serve as nominal head of the mission and would hope that I could spend at least a month in Japan, probably during late August and September. I would be accompanied by Mr. Wilbur J. Cohen, the Assistant Director of Research and Statistics of the Social Security Administration.

"I would want Mr. William H. Wandel, Chief of the Program Division, Bureau of Employment Security, to serve on the mission. In order to do necessary preparatory work, he should precede us to Japan by about 3 months and should remain for about 3 months after our visit in order to finish any necessary details.

"I should think it advisable, and would recommend, that while in Japan on the mission, Mr. Wandel also serve as chief, Social Insurance Division, public health and welfare section, staff of the supreme commander. If such an arrangement can be made, I believe it would greatly facilitate the preparatory background work to be done and add to the success of the mission.

"I would recommend that there be included in the mission a person specially qualified on public welfare to cover the field of assistance, relief, and family and child welfare services.

"I would also recommend that Mr. Anton and Dr. Lee Janis be included in the mission and that, insofar as possible, the services of Mr. Stanchfield be made available to the mission.

"I am leaving next week to go to Geneva, Switzerland, as executive secretary of the Preparatory Commission for the International Refugee Organization. I shall return to Washington about August 1. In the meantime, if you desire that the Social Security Administration help you in any way, either along the lines outlined above or in some other manner, please get in touch with Mr. Wilbur J. Cohen."

Please advise status of request for such a mission so that answer can be given Altmeyer.

Telecon—TKG–WCR—14/0105/Z.

Present here i. e., Tokyo, Japan: Col. W. D. Tigert, 406 Med. Lab.; Col. C. F. Sams, Chief, P. H. and W.; Mr. P. I. Stanchfield, ESS/LD; Mr. Geo. F. Pollock, Deputy Chief, Social Security and Insurance Division; Miss Leone M. Moore, personnel coordinator, P. H. and W.; Miss R. Sullivan, Civilian Personnel Section.

Subject: Personnel for Social Security and Insurance Division, P. H. and W. S. and 406th Med. Gen'l Lab.

Classification: Unclassified.

FEC item 1.

Reur WD 1 concur in proposal of Mr. Altmeyer, Mr. Wandel can be employed by OSW for 6 months' period on reimbursable basis and designated as Chief of Social Security Division, P. H. and W., while in Japan, according to Office Civilian Personnel here. Firm request will be forwarded with air priority for Mr. Wandel by radio for him to arrive in Japan May 1. Radio will also be forwarded within next few days extending formal invitation for social-security mission. Desire arrangements be made for successor to Wandel to arrive Japan by September 1 to insure 1 month overlap if possible. Neff is Chief of Welfare Division, Evans is Chief of Welfare Institutions, Markusson is Public Assistance Chief, and Ernest Witte is scheduled to arrive as social-work training consultant. If Altmeyer desires additional member for welfare on mission, it is agreeable to P. H. and W. Suggest Mr. Falk.

WD–12 Reur item 1.

This is good news. Will advise Altmeyer immediately and work out further details with you by radio.

FEC item 2.

From Civ. Pers. Sec. to CAD. Reference radio WCL 28919, March 13, GHQ Reqn 1312 G–1. Request that individuals selected be processed and furnished travel earliest. Disregard request in OURAD ZX–38061 for names and summary of qualifications prior to appointment. Grades for appointments are as follows:

8th Army—CAF–11.
FEAF—CAF–12.
Korea—CAF–12.
Guam (Marbo)—CAF–11.

WD–13—Reur item 2.

Info will be passed to OSW/CPD who is handling.

WD–2—For Colonel Tigertt.

For position senior parasitologist, P–6, recommend Dr. Donald B. McMullen, age 43; G. S., chemistry and biology, Tarkio College; M. S., zoology, Washington University; Sc. D. helminthology, Johns Hopkins; 30 hours additional graduate study in Cheboygan parasitology, University of Michigan; 1938 to present, associate professor, preventive medicine, Oklahoma University school of medicine, teaching parasitology and phases of public health and conducted research in parasitology; 1939–42, summer, director, division of water-itch control, University of Michigan biological station stream-control commission, Michigan; 1928–38, head, biology department, Monmouth College; 1925–28, graduate assistant in zoology, Washington University; April 1945–46, member of commission on schistosomiasis, control of tropical disease, Army epidemiological board, preventive medicine service, SGO, doing research on diagnosis, distribution, epidemiology, and control of schistosomiasis in Philippines and Japan; highly recommended for position by Dr. E. C. Faust, professor of tropical medicine, Tulane; Dr. W. W. Cort, professor of helminthology, Johns Hopkins; and Dr. H. E. Meleny, chairman, committee on tropical diseases, National Research Council; Dr. Stull believes McMullen very well qualified. McMullen will be available about May 25. Recruitment for Eighth Army positions is presently suspended, therefore, if you desire McMullen it will probably be necessary for command channel request to be received to effect his recruitment.

FEC item 6.

Reur WD 2, McMullen acceptable for parasitologist, P–6. Will attempt command channel request.

FEC Item 12.

Reur WD 2, wd8, will attempt to initiate blanket authorization for continued recruitment for parasitologist P–6 and bacteriologist P–6.

WD–3.

Phil Booth seems to be best available for Chief, Economics Analysis Branch, CAF–13, S. S. and I. Division, and will be available for at least a year. Dr. Wigert and Mr. Zempel believe you should take him for the post on 1-year basis. In this connection, Altmeyer is only willing to release people from Social Security Board only for 1 year; however, that part of regulations calling for 2-year contract can be waived in cases like this.

FEC item 3.

Reur item 3. Mr. Booth is acceptable on 1-year basis if waiver can be obtained by you.

WD–14 Reur item 3.

Can arrange * * *!

WD–4—For Colonel Tigertt.

Have received your radio concerning desire for Dr. Hartmann's services in September; will attempt to secure him for you at that time.

FEC item 7.

Reur WD 4. Hartman will be needed in September.

WD–5—For Colonel Tigertt.

Understand Dr. Stull has informed you of Dr. Knudson who is prospective candidate for senior chemist position. Have as yet received no reply from Knudson confirming his availability. But if he replies in the affirmative, will attempt to ship him to Japan at earliest posible date if this meets with your desires.

FEC item 8.

Reur WD 5. Desire Knudsen as senior chemist.

WD–6:

Dr. Janis, Chief, Health Insurance, is in process but ETD not certain probably departs first part of April.

WD–7:

For economic analyst, P–5, recommend George F. Rohrlich, age 33, JD., University of Vienna; Ph. D., social security, political economy, and government, Harvard; additional graduate study in national income and labor statistics, American University, Brookings Research Training Fellowship, 41–42; worked with SSB in 41–42; writing ph. D. thesis on Financial Problems of Unemployment Insurances in United States and abroad. Has published extensively in field of social security and unemployment compensation; 39–41, various research assistantships with Social Security Research Council, Bureau for Research in Municipal Government, Harvard and Brookings Institute: 42–45, instructor, economics and government, Sweetbriar College; 45–present, research analyst, P–5, State Department, studying government finance, labor sources, living standards, health, welfare, education and population and migration in Latin America. Dr. Weigert has talked with Rohrlich and believes him well qualified for the post. He has never been employed by SSB, but has been a student of social security so long that he is as well versed as many good people in the Board. He has set his sights for top economics analysis spot, and only will accept P–5 post if someone like Booth or other competent individual takes top job. Rohrlich's family has just had baby and Rohrlich would not be available for 3 or 4 months. Suggest you take him providing better candidate doesn't appear in meantime.

FEC item 4.

Reur item 7. Rohrlich is acceptable under conditions stated as P–5 economic analyst.

WD–8—For Colonel Tigertt.

Expect to forward recommendation for senior bacteriologist in few days.

FEC item 9.

Reur WD 8. Senior bacteriologist is urgently needed now. Can recruitment be accomplished on our now existing requests?

WD–15—Reur item 9.

Yes. However, in view of suspension indicated earlier special clearance will have to come through on each individual.

WD–9—For Stanchfield.

Reference to requestion 1184, dated January 22, requesting recruitment for position educational specialist, Labor Division, CAF–11, Mr. James D. Hoover has been recruited for this assignment. Mr. Hoover has been interviewed by Theodore Cohen who is now in Washington, and Hoover will depart for Tokyo in approximately 10 days by air.

WD-10:

Dr. McDougall was physically disqualified for Assistant VD Control Officer job. Hope to have cable on the way next week recommending a Dr. Dowiatt for the post.

WD-11—

Hope to send Monsignor Flanagan and his secretary as expert consultants on child welfare by April 1. Radio request for April goes forward tomorrow. Please expedite.

FEC item 5.

Reur item 11. Will expedite air priority on Flanagan and secretary.

FEC item 10.

Suggest George Perratt, USPHS, be included in mission as study is now under way here on drafting national health bill for Japan. By Japanese council especially established for the purpose by ministry of health and welfare. National and prefecture hospital systems to be integrated with health-insurance program and public-health center system.

WD-16—Reur item 10.

Will try to secure Perratt.

FEC item 11.

Suggest possible inclusion in the Altmeyer mission of Dr. Oscar Weigert and/or Dr. Tillman Sogge, formerly in Tokyo as members of labor advisory committee, if they can be available Weigert can be contacted through CAD at Bureau of Labor Statistics, Labor Dept., Washington. Sogge is at St. Olaf's College, Minn., and has indicated he might be available during summer vacation.

WD-17—Reur item 11.

Dr. Sogge and Dr. Weigert are excellent suggestions and feel sure they will come if at all possible. Include them and Perratt in cable requesting invitation to Altmeyer.

FEC Item 13.

For Theodore Cohen, c/o David Marse, Labor Department, from Stanchfield.

In view of Haber's unavailability, suggest that William Shaughnessy, of United States Employment Service, be recruited as chief of manpower branch, if available. Would Eugene Vinogvadoff, of USES, be available as reimbursable consultant on labor exchanges and labor market analysis.

WD-18—Reur item 13.

Believe Cohen is trying to get Vinogrodoff for Chief, Manpower Branch. Will pass your item to Cohen.

FEC Item 14.

For Cohen from Stanchfield:

Either Vinogradoff or Shaughnessy would be excellent for chief of branch, suggested Shaughnessy because he seemed more likely to be available for permanent job.

(The bills submitted by Senator Pepper are as follows:)

[S. 855, 75th Cong., 1st sess.]

A BILL To aid in alleviating the loss caused by sickness

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

DEFINITIONS

Section 1. As used in this Act—

1. "Board" means the Federal Health Insurance Board created by this Act.

2. "State authority" means the central State agency or officer charged with the administration of a State system of health insurance.

3. "State" includes the District of Columbia.

4. "Fund" means the health insurance fund established by a State.

5. "Employer" means any person, partnership, firm, association, public or private corporation, the legal representatives of a deceased person, or the receiver, trustee, or successor of a person, partnership, firm, association, public or private corporation, including the State, municipal corporations, other governmental subdivisions, and all public agencies and authorities having three or more persons employed in any employment as defined by this Act. Whenever any helper, assistant, or employee of an employer engages any other person in the work which said helper, assistant, or employee is doing for the employer, such employer shall for all purposes hereof be deemed the employer of such other person, whether such person is paid by the said helper, assistant, or employee, or by the employer, provided the employment has been with the knowledge, actual, constructive, or implied, of the employer.

6. "Employee" means any person, including aliens and minors, employed for hire by an employer in an employment as defined by this Act, except any person employed at other than manual labor receiving wages in excess of $60 per week.

7. "Employment" means any employment of an employee by an employer in which all or the greater part of the employee's work is performed within a State under any contract of hire, express or implied, oral or written, and shall include any trade, occupation, service, or profession in which any person may engage; except that for the purpose of this Act it shall not include—

(a) employment as a farm laborer; and

(b) employment in the personal or domestic service of an employer having less than three employees engaged in such service.

8. "Wages" means every form of remuneration received by an employee from an employer, including wages, salaries, commissions, bonuses, the reasonable money value of board, rent, housing, lodging, or similar advantages.

9. "Full-time daily wages" means the daily wages that an employee would receive at current rates but for his disability. Each State authority may make such rules and adopt such methods of calculating full-time daily wages as may be suitable and reasonable under this Act and under the conditions prevailing in the particular State.

10. "A day of employment" means any day in which an employee has had employment for all or any part of the day with an employer and in an employment as defined by this Act.

11. "A day of voluntary cash insurance" means any day during which voluntary cash and maternity benefits have been secured and "a day of voluntary medical insurance" means any day during which voluntary medical benefits have been secured.

12. "Disability" means the inability of an employee, because of sickness or injury, to continue in the employment in which he is then engaged, though such employment be one not within the definition of this Act; or, if the employee be then unemployed, the inability, because of sickness or injury, to accept immediately available work in any employment for which he is reasonably fitted by training and experience, including employments not within the definition of this Act: *Provided, however*, That in no case shall disability be deemed to exist if an employee engages in any gainful occupation.

13. "Loss due to disability" means a total lack of wages because of disability.

14. "Disabling sickness or injury" means any sickness or injury causing disability.

CONDITIONS FOR THE APPROVAL OF STATE SYSTEMS OF HEALTH INSURANCE

SEC. 2. A State system of health insurance shall be approved only when the Board finds that it complies with the conditions, standards, and provisions contained in this section, as follows:

1. Fund: The fund out of which benefits are paid is created and maintained by regular contributions thereto equal to at least 6 per centum of the total of all wages periodically paid by employers to employees. Not less than one-quarter of such contributions shall be made by the State out of its treasury. The other three-quarters may be divided between employers and employees: *Provided*, That employees receiving wages of $20 a week or less shall not contribute amounts greater than 1 per centum of such wages; employees receiving wages in excess of $20 but not exceeding $40 a week, shall not contribute amounts greater than 2 per centum of such wages; and employees receiving wages in excess of $40 a week shall not contribute amounts greater than 3 per centum of such wages. All such contributions shall be paid into a single, State-wide fund to be held

and administered by the State. Employees' contributions shall be deducted by employers from their wages and remitted to the fund and until so remitted shall be set apart and held by the employers as trust funds.

2. Cash benefits: (a) Cash benefits shall be paid to an employee for loss due to disability, after an uncompensated waiting period of not less than three, nor more than five days, at the rate of 50 per centum of the employees' full-time wages, if the employee has no dependent wife or children. A maximum shall be imposed on such benefit which shall be not less than $15 nor more than $25 a week. To this benefit shall be added an additional 10 per centum with a maximum of not less than $3 nor more than $5 a week for a dependent spouse, and an additional 5 per centum with a maximum of not less than $1.50 nor more than $3 a week for each dependent child not exceeding three. Such cash benefit shall be payable for at least one hundred and fifty-six cumulated days of loss due to disability in each consecutive fifty-two weeks. No cash benefit need be paid for loss due to any disability for which the employee is entitled to money benefits under any workmen's compensation act.

(b) As a qualification for receiving cash benefits there shall be required not less than ninety nor more than one hundred and four days of employment and/or of voluntary cash insurance within the twelve months preceding the day on which the claim for cash benefits is made or (in the alternative) not less than one hundred and forty nor more than one hundred and sixty such days within the twenty-four months preceding said day.

(c) An employee, qualified for cash benefits in accordance with clause (b) of this subsection, shall, on ceasing to be employed in an employment as defined by this Act, be entitled to have his said qualification extended for a period equal to one day for every five days of employment and/or of voluntary cash insurance during the preceding five years and should he suffer a loss due to disability during said extended period, he shall be deemed qualified for cash benefits if otherwise entitled thereto.

3. Maternity benefits: (a) Cash maternity benefits shall be paid to a woman employee for not less than six weeks prior to the birth of a child and for not less than six weeks after the birth of a child, in amounts equal to the cash benefits which such employee would be entitled to receive for loss due to disability. Such benefit shall be paid only on condition that the employee refrains from all gainful occupation during said period and has received prenatal care.

(b) To qualify for the cash maternity benefit, an employee shall be required to have not less than two hundred nor more than two hundred and fifty days of employment and/or of voluntary cash insurance during the twenty-four months preceding the day on which the said benefit is to commence.

(c) The period during which the cash maternity benefit is paid shall not be included within the maximum period for which the employee is entitled to receive cash benefits for loss due to disability.

(d) On the birth of a child, a sum of not less than $15 nor more than $25 shall be paid to a woman employee entitled to receive the cash maternity benefit, to the wife of an employee qualified to receive cash benefits for loss due to disability, and to the widow of such an employee so qualified at the time of his death, if the child be born within ten months of his death.

(e) Women employees, on ceasing to be employed in an employment as defined by this Act, shall have the right of an extension of their qualifications for the cash maternity benefit similar to that granted to employees with respect to their qualification for cash benefits for loss due to disability in accordance with the provisions of clause (c) of subsection 2 of this section.

4. Medical benefits: (a) Medical benefits shall be provided for employees, their dependent spouses, and dependent children and such other members of their family who are dependent on them and live in the same household.

(b) Medical benefits shall be provided immediately on the occurrence of sickness or injury and to qualify for such benefits an employee shall not be required to have more than ten days of employment and/or of voluntary medical insurance within the three months preceding the day on which the furnishing of medical benefits is to commence for him or any of his dependents.

(c) Medical benefits need not be provided for any person in respect to any sickness or injury for which such person is entitled to medical treatment under any workmen's compensation act.

(d) Medical benefits shall consist of not less than—

1. The service of a physician in general practice at the office, home, hospital, or elsewhere, in preventive diagnostic, and therapeutic treatment and care, which shall include immunizations and periodic physical examinations.

2. On the prescription of the physician in charge, general and special hospital treatment and care which shall include nursing and the other usual hospital services.

3. Prenatal and maternity treatment and care in the home or in the hospital.

4. On the prescription of the physician in charge, the services of a surgeon, diagnostician, medical, or other specialist at the office, home, hospital, or elsewhere.

5. On the prescription of the physician in charge, the services of laboratories and clinics.

6. The services of a dentist in general practice in exodontia, plastic fillings, and prophylactic treatment and care.

7. The services of a dentist in general practice in such other treatment and care, including restorative work, as may be found necessary to correct conditions which are seriously prejudicial to health, or are causing or threatening to cause disability, or are interfering or threatening to interfere with the pursuit of a gainful occupation.

(e) There shall be no limitation upon the said medical benefits except that the following may be imposed—

1. The benefit stipulated in paragraph 2 of clause (d) of this subsection need not be provided, in connection with any one sickness or injury, beyond a period of one hundred and eleven days, of which at least the first twenty-one days shall be without charge and the remaining ninety days may be at a charge of not more than 25 per centum of the cost of such benefit.
Such benefit need not be furnished to any person sixty-five years of age or over for more than ninety days in any consecutive one hundred and four weeks.

2. In the event of a disabling sickness or injury, the benefits stipulated in paragraphs 1 and 7 of clause (d) of this subsection need not be provided beyond a period of twenty-six weeks and the benefits stipulated in paragraphs 4 and 5 of said clause beyond a period of twelve weeks.

3. In the event an employee because of disability or for any other reason whatever becomes unemployed or ceases being employed in an employment as defined in this Act, the benefits stipulated in paragraphs 1 and 7 of clause (d) of this subsection which he or any of his dependents may be receiving or may thereafter receive in connection with any one sickness or injury need not be provided beyond a period of twenty-six weeks and the benefits stipulated in paragraphs 4 and 5 of said clause beyond a period of twelve weeks: *Provided, however*, That if such employee, prior to the expiration of the said twelve-week period, secures voluntary medical insurance, the said benefits shall be continued with respect to the said sickness or injury as long as he continues to secure voluntary medical insurance.

(f) Additional medical benefits other than those hereinbefore stipulated in clause (d) of this subsection may be furnished entirely at the expense of the fund or partly at the expense of the fund and partly at the expense of the persons receiving such additional medical benefits.

(g) Provision shall be made for extending the qualification of the right to medical benefits in case an employee ceases being employed in an employment as defined in this Act in the same way as the extension of the qualification for cash benefit for loss due to disability in accordance with the provisions of class (c) of subsection 2 of this section.

5. Voluntary insurance: Provision for voluntary insurance shall be made as follows:

(a) Every person employed in an employment not within the definition of this Act, who is not older than sixty-five years and whose wages are $60 a week or less, shall be entitled voluntarily to secure on the same conditions the cash and maternity benefits regularly provided for employees, by regularly contributing to the fund a percentage of his wages equal to one-fourth of the combined percentage required of employers and employees.

A health examination may be required as a condition to obtaining such voluntary insurance but no such health examination shall be required of any person who within the preceding three years had two hundred and sixty-days of employment and/or voluntary cash insurance.

(b) The following shall be entitled voluntarily to secure for themselves and their dependents on the same conditions the medical benefits regularly provided for employees and their dependents:

1. Every person not suffering disability whose net income from whatever source is $60 a week or less and who is not older than sixty-five years.

Such person shall regularly contribute to the fund a percentage of his income equal to three-fourths of the combined percentage required of employers and employees.

2. Every person not suffering disability who within the preceding three years had two hundred and sixty days of employment and/or of voluntary medical insurance and whose net income from whatever source does not exceed $100 a week.

Such person shall regularly contribute to the fund a percentage of his income equal to three-fourths of the combined percentage required of employers and employees.

3. Every person who within the preceding three years and two hundred and sixty days of employment and/or of voluntary medical insurance and who is unemployed, though capable of and available for employment.

Such person shall regularly contribute to the fund a percentage of his average weekly income during the preceding three years which is equal to three-fourths of the combined percentage required of employers and employees.

4. Persons who are receiving old-age or unemployment benefits or relief from any governmental or public officer or agency, if such officer or agency regularly pays into the fund such amounts as may be fixed by the State authority, which amounts shall be fixed so as most equitably to rate the risk and distribute the cost of the benefits.

5. A health examination may be required as a condition to obtaining voluntary medical benefits, but no such examination shall be required of any person who within the preceding three years had two hundred and sixty days of employment and/or of voluntary medical insurance nor of the dependents of any such person.

(c) All of the terms, provisions, and conditions of the system governing cash, maternity, and medical benefits to employees shall apply to persons obtaining voluntary cash, maternity, and/or medical benefits.

(d) The State shall pay into the fund amounts equal to one-third of all sums paid into the fund by persons securing voluntary cash, maternity, and/or medical benefits.

6. Administration: (a) The system shall be administered by a central State department, commission, or other agency or officer through a system of local public boards, bureaus, officers, or other agencies.

(b) The State authority shall have the power to establish standards of administration for the system, to make all such rules and regulations as may be required for the administration thereof, and to amend and modify any of the said rules and regulations from time to time as may be found necessary or desirable.

(c) The system shall have one or more State and local advisory councils, the members to be representative of employers, employees, and the public and the professions furnishing the medical benefits and to serve without salary but with allowances for actual and necessary expenses.

(d) Excepting the members of the State authority and the advisory councils, all persons engaged in the administration of the system shall be appointed or employed and shall hold office on a merit-rating basis through open competitive examinations of a standard not interior to that prescribed for the United States Civil Service.

(e) The State authority shall be empowered to obtain from all employers and employees within its State, including those not subject to the provisions of the system, all such information as it may require in the administration of the system, to make reports on such administration as often and in such form as the same may be required by the Board and, from time to time, to make such other reports and such suggestions to the Board with respect to such administration and the operation of this Act as it may think fit.

(f) The State authority shall be empowered to submit to the Board in advance an estimate of the expenditures necessarily to be incurred in the administration of the system.

(g) Provision shall be made for the removal, after a hearing on written charges, of any physician or dentist in general practice, surgeon, other medical or dental specialist, hospital, clinic, laboratory, or other person or agency from the list of those who have agreed or with whom arrangements have been made to furnish medical benefits provided by the system when the continued inclusion of such person or agency would be prejudicial to the adequate, proper, or efficient furnishing of the medical benefits.

(h) Provision shall be made for furnishing medical benefits to such persons entitled to the same under the system who are not residents of the State in any manner that seems to be most feasible, including the payment to such persons of sums equivalent to the cost of the medical benefits to which they are entitled.

(i) The State authority shall be empowered to make inquiries into the causes and results of sickness and injuries, the sources of mortality and the effect of localities, employments, and other conditions upon the health of the persons entitled to the benefits provided by the system; to obtain, collect, preserve, and, from time to time, publish such information relating to mortality, sickness, injury, and health as may be useful in the administration of the system or may contribute to the promotion of health or the security of life; to promote the health and safety of the persons entitled to the benefits provided by the system and to take such steps within its means as it may deem feasible and appropriate to reduce and prevent sickness, injury, and death among such persons; to cooperate with public-health officers and all other agencies, public and private, in the improvement of public health and sanitation, and in the promotion of public education in all matters pertaining to health.

(j) Provision shall be made for fixing the manner of remunerating physicians and dentists in general practice, surgeons, and other medical and dental specialists, pharmacists, nurses, hospitals, clinics, laboratories, and the other persons and agencies furnishing the medical benefits.

Any one of the following modes may be adopted for remunerating physicians and dentists in general practice—

1. a salary system;
2. a per capita system whereunder payment will be based on the number of persons entitled to medical benefits included in the practioner's list;
3. a fee system whereunder payment will be based on the extent and character of the treatment given and services rendered by the practioner to persons entitled to medical benefits; and
4. any combination or modification of the systems hereinabove stipulated.

No mode of remunerating physicians and dentists in general practice shall be adopted for any local area within the State without the consent of a majority of such physicians or such dentists, respectively, in that locality who have agreed to furnish medical benefits under the system.

(k) Every duly qualified physician and dentist engaged in general practice in the State, who so desires, shall have the right to be included in the list of those furnishing the medical benefits stipulated in paragraphs 1, 6, and 7 of clause (d) of subsection 4 of this section, prepared and published for each local area in the State in which he engages in practice, subject to being remunerated for his services in the manner fixed for the local area in which his services are rendered.

(l) Every person entitled to the medical benefits stipulated in paragraphs 1, 6, and 7 of clause (d) of subsection 4 of this section shall have the right to select the physician engaged in general practice and the dentist engaged in general practice by whom he wishes to be attended and treated, from the list of such practitioners prepared and published for any local area in the State, irrespective of the local area in which such person may reside or be employed, subject to the consent of the practitioner so selected, and the right at any time to change the selection so made on such notice as the State authority may prescribe.

(m) Any person claiming benefits shall in accordance with such rules as the State authority may prescribe register at the office in the local area in which he resides or in which he was last employed or in such other area as may be designated. After so registering a person claiming benefits shall give notice of his continuing right to such benefits as often and in such manner as shall be prescribed.

(n) Any person claiming cash or maternity benefits shall for the time that such benefits are claimed correctly report any wage-earning employment had during such time and any wages received for such employment, including employments not within the definition of this Act, and shall make such reports in accordance with such rules as shall be prescribed.

(o) Claims, complaints, and controversies with respect to contributions to the fund, the remuneration of those furnishing the medical benefits, the adequacy, quality, and extent of the medical benefits shall be determined by a local public officer employed on regular salary. A claimant and any other party affected shall be entitled to a hearing before such officer and there shall be a right to an appeal from the determination of such officer to a State agency. Claims and appeals shall be presented, heard, and determined in accordance with such rules and procedure as may be prescribed, but shall not be controlled by common law or statutory rules of evidence or by the technical or formal procedure employed in civil actions.

(p) No agreement by an employee to waive any right or benefit under the system shall be valid; nor shall benefits be assigned, pledged, encumbered, released, or commuted, and such benefits shall be exempt from all claims of creditors and from levy, execution, and attachment or other remedy now or hereafter provided for recovery or collection of a debt, which exemption may not be waived.

(q) Penalties shall be provided for any person who willfully makes a false statement or representation to obtain any benefit or payment under the provisions of the system, or to obtain payment or remuneration for services rendered or materials supplied in furnishing any of the benefits provided by the system, either for himself or for any other person, or to lower payments to be made to the fund; or who willfully refuses or fails to make any payment to the fund; or who fails to set apart and hold as a trust fund the amounts deducted from an employee's wages to pay the contributions required of such employee; or who refuses to allow the State authority or its authorized representatives to inspect pay rolls or other records or documents relative to the enforcement and administration of the system; or who makes a deduction from the wages of any employee to pay any portion of the contributions which an employee is required to make or in any other manner collects from an employee any portion of the contributions required to be paid by an employer; or who violates any of the provisions of the system or does any act prohibited by the system, or fails, neglects, or refuses to perform any duty lawfully enjoined by the system, or fails, neglects, or refuses to obey any lawful order given or made by the State authority or any judgment or decree made by any court in connection with the provisions of the system.

(r) The administration of the cash and maternity benefits provided for by the system shall, so far as it is practicable, be kept separate and apart from the administration of the medical benefits and all certificates of right to cash, maternity, and/or medical benefits shall be made by public officers. No physician, dentist, or other person or agency engaged in furnishing the medical benefits provided by the system, other than a public officer, shall be required to make any such certification.

7. Subrogation. If any of the benefits provided by the system are paid or furnished in the event of sickness, injury, or disability, to any person who by reason of such sickness, injury, or disability, has a right or claim for compensation or benefits under any workmen's compensation act or any employers' liability act or otherwise against his employer or any other person for causing such sickness, injury, or disability and for the damages resulting therefrom, the fund created by the system shall, to the extent of the said benefits so paid and the cost thereof so furnished, be entitled to reimbursement out of any sum or damages which said person receives by way of compensation or benefits or through suit, settlement, or judgment and the fund shall, to said extent, be subrogated to the said right or claim. Upon notice to the one against whom said right or claim exists or is asserted the amount to which the said fund is so entitled by way of reimbursement shall be a lien upon said right or claim and the said sum or damages paid or received thereunder. Suitable provision shall be made to enable the State authority to enforce the right of reimbursement created in favor of the said fund.

8. The fund. (a) The fund created by the system shall consist of all contributions and money paid into and received by the fund; of property and securities acquired by and through the use of moneys belonging to the fund; and of interest and other income earned by the fund. One-fourth of all contributions and money paid into the fund, in accordance with the provisions of subsection 1 and clause (d) of subsection 5 of this section, and all the contributions and money paid into the fund by persons securing the voluntary cash and maternity benefits shall, together with the interest and income earned thereon, be held and accounted for separately and the same shall be used to pay the cash and maternity benefits provided by the system, the entire cost of administering the said benefits and such portion of all other expenditures as is properly allocable to the administration of the said benefits. The other three-

fourths of the contributions and money paid into the fund, in accordance with the provisions of subsection 1 and clause (d) of subsection 5 of this section, and all the contributions and money paid into the fund by persons securing the voluntary medical benefits shall, together with the interest and income earned thereon, be held and accounted for separately and the same shall be used to pay the cost of the medical benefits provided by the system, the entire cost of administering the said benefits, and such portion of all other expenditures as is properly allocable to the administration of the said benefits.

(b) The State treasurer or other State officer performing similar duties shall be the custodian of the fund and all disbursements therefrom shall be paid by him upon vouchers of the State authority.

(c) Any portion of the fund not needed for immediate use shall be deposited in the same manner and subject to all provisions of law with respect to the deposit of other State moneys; and all interest earned by such portion of the fund as may be so deposited shall be collected and placed to the credit of the fund.

(d) Any of the surplus or reserves belonging to the fund may, by order of the State authority, approved by the State treasurer or other State officer performing similar duties, be invested in any obligations of the United States of America or in obligations of the State. The State authority may sell any of such certificates.

AUTHORIZATION AND APPROPRIATION

Sec. 3. There is hereby authorized to be appropriated annually, out of any money in the Treasury not otherwise appropriated, the sum of $200,000,000, to be apportioned among the States in accordance with the provisions and subject to the conditions herein contained to aid them in developing and maintaining adequate systems of health insurance.

ALLOTMENTS TO APPROVED SYSTEMS OF HEALTH INSURANCE

Sec. 4. 1. The Board shall examine each State system of health insurance which may be submitted to it for approval and shall approve each such system which it finds, in its terms and in its actual administration, conforms to the provisions of section 2 of this Act.

2. The Board shall out of the sum authorized and appropriated by section 3 of this Act annually allot to each approved State system an amount equal to one-quarter of the total contributions paid into and received by the fund created under such system.

3. The Board shall annually notify the Secretary of the Treasury of the amounts of the allotments which it has made pursuant to the provisions of this section and the Comptroller General is authorized and directed to enter in the accounts of the Treasury of the United States severally to the credit of each of the approved State systems the amounts allotted to such systems pursuant to the notices of the Board.

4. The Secretary of the Treasury is authorized and directed periodically to pay over to each approved State system out of and to the extent only of the total of the amounts allotted and standing to the credit of the said system, together with the income thereon such sums as the State authority may, with the approval of the Board, from time to time requisition.

5. The Board may at any time suspend or revoke its approval of any State system of health insurance when, after investigation and hearing, it finds that the system is not being maintained or the benefits provided thereunder are not being furnished in conformity to the provisions of section 2 of this Act or that the system is not being administered adequately, properly, or efficiently. When the approval of any system is suspended or revoked by the Board, no further payments shall be made to such system out of any allotments then standing to its credit so long as such suspension or revocation remains effective, nor shall any further allotments be made to said system during such period.

6. The Secretary of the Treasury is authorized and directed to hold the total of all allotments annually made by the Board pursuant to the provisions of this section in a separate account at the Treasury or at any bank or banks designated by him, to receive and hold the income derived therefrom, to invest such portion thereof as is not required to meet current requisitions in any primary obligations of the United States or in any obligations guaranteed both as to principal and interest by the United States and to sell the same from time to time as he deems advisable. He shall enter quarter yearly to the credit of the account of each

approved system a proportionate part of the income derived during the preceding quarter, on the basis of the average daily balance of such account. He is hereby authorized to appoint any one or more of the Federal Reserve or national banks as his agents, on such terms and conditions as he may prescribe, to hold and have custody of the total of the said allotments or any portion thereof and such banks are hereby authorized to act as such agents.

7. When any allotment made pursuant to this Act or any installment thereof is withheld by the Board, the State authority administering the system affected may appeal to the President of the United States, who may affirm, modify, or reverse the action of the Board in whole or in part. The Board on receiving written notice of the decision of the President shall promptly take action in conformity therewith in order to execute the same.

8. The total allotment made to an approved State system pursuant to this Act shall be used solely to extend, increase, or amplify the cash, maternity, and/or medical benefits regularly provided under the system and no part thereof shall be used to pay or furnish any of the cash, maternity, and/or medical benefits regularly provided for under the system, but in no event shall more than one-quarter of the total of the said allotment be used to extend, increase, or amplify the cash or maternity benefits.

9. Before any sum is paid over out of the amounts allotted and standing to the credit of an approved State system the State authority shall submit to the Board in detail a plan showing how such sum is to be disbursed and shall receive the Board's approval thereof.

ADMINISTRATION

Sec. 5. 1. Federal Health Insurance Board: This Act shall be administered by a Board hereby created, which shall be known as the Federal Health Insurance Board. This Board shall be composed of the Director of Health Insurance, who shall be the chairman thereof, and two members appointed by the President, with the advice and consent of the Senate.

2. Term of Board: The two appointed members of the Board shall be designated by the President within thirty days after the enactment of this Act. One member shall be appointed for the term of three years and one member for six years; and thereafter as their terms expire the President shall appoint or reappoint members for the term of six years. The President may at any time remove any member of the Board for cause after a hearing on written charges. Vacancies shall be filled for the unexpired term by appointment by the President, with the advice and consent of the Senate.

3. Compensation of Board: Each of the two appointed members of the Board shall receive an annual salary of $10,000. In addition, each member shall be allowed actual and necessary traveling and incidental expenses.

4. Organization of Board: A majority of the Board shall constitute a quorum to transact business. No vacancy shall impair the rights of the remaining members to exercise all of the powers of the Board so long as a majority remains. Any investigation, inquiry, hearing, review, or appeal which the Board is authorized to hold or undertake may be held or undertaken by or before any one member of the Board, or by or before one or more of the deputies; and every order made by a member thereof, or by one or more of its duly authorized deputies, when approved and confirmed by a majority of the Board, and so shown on its record of proceedings, shall be deemed to be the order of the Board.

5. Office of Board: The Board shall maintain its principal office in the city of Washington. It shall provide itself with a seal for the authentication of its rules, orders, awards, and proceedings. The Board may hold sessions in any place within the United States.

6. Duties and powers of the Board: The Board shall enforce and administer this Act and shall have all the duties, powers, and authorities imposed and granted by this Act. In addition, it shall have the following duties, powers, and authorities—

(a) to make all such rules and regulations as may be required for the administration and enforcement of this Act, and to amend and modify any of its rules and regulations from time to time as it may find necessary or desirable;

(b) to appoint or employ such employees and assistants as may be required for the administration of the provisions of this Act, and to determine their salaries and duties. All such persons appointed or employed by the Board shall be in the competitive class of the civil service and shall be appointed or employed under civil-service regulations;

(c) to make inquiries into the administration of approved State systems of health insurance and the furnishing and payment of the benefits provided thereunder and to cooperate with the State authorities in order to make the administration thereof more adequate and efficient;

(d) to cooperate with State authorities and all other officers and agencies, public and private, in promoting the health and safety of the persons entitled to benefits under approved State systems of health insurance, in reducing and preventing sickness, injury, and death among such persons and in improving public health and sanitation generally; to obtain, collect, preserve, and, from time to time, publish such information relating to mortality, sickness, injury, and health as may be useful in the administration of this Act or of approved State systems of health insurance or may contribute to the promotion of health or the security of life.

7. Director of Health Insurance: The President shall, with the advice and consent of the Senate, appoint for a term of six years a Director of Health Insurance. The President may at any time remove the Director for cause after a hearing on written charges. The Director shall receive an annual salary of $11,000 and in addition shall be allowed actual and necessary traveling and incidental expenses.

8. Duties and powers of the Director: The Director shall be the chief administrative officer under this Act and shall have all the duties, powers, and authorities imposed and granted by this Act or assigned to him by the Board. As representative of the Board and under its direction he shall supervise, direct, and control the administration and enforcement of this Act.

9. Federal advisory council: There is hereby created a Federal advisory council of twelve members to be appointed by the President. Three of the appointees to this council shall be representative of employers, three shall be representative of employees, three shall be representative of the professions engaged in furnishing medical service, and three shall be representative of the public. One representative of the employers, one representative of the employees, one representative of the professions, and one representative of the public shall be appointed for a term of two years; one representative of the employers, one representative of the employees, one representative of the professions, and one representative of the public shall be appointed for a term of four years; and one representative of the employers, one representative of the employees, one representative of the professions, and one representative of the public shall be appointed for a term of six years; and thereafter as their terms expire the President shall appoint or reappoint members for the term of six years. The said council shall consider and shall advise the Board upon all matters connected with the administration of this Act submitted to it by the Board and may recommend upon its own initiative such changes in the administration of this Act as it deems necessary.

OATHS AND SUBPENAS

Sec. 6. 1. The Board, each member of the Board, its secretary and its deputies, the Director of Health Insurance, and his deputies and other duly authorized representatives of the Board shall for the purposes of this Act have power to examine under oath any employee, any employer, or the officer, agent, representative, or employee of any employer, any member of a State authority of a State system of health insurance, any person employed or engaged in the administration of any such system, and any person, institution, or agency and the officer, agent, representative, or employee of any person, institution, or agency interested or participating in or affected by the administration of this Act or the administration of any State system of health insurance, and shall have power to administer oaths, certify to official acts, take depositions, issue subpenas, compel the attendance of witnesses, and the production of books, accounts, papers, records, documents, and testimony.

REPORTS

Sec. 7. Annually, on or before the 1st day of March, the Board shall make a report to the Congress for the preceding calendar year, which shall include a detailed statement of the number of persons covered by approved State systems of health insurance, the number receiving benefits thereunder, the amounts disbursed in the payment and furnishing of the benefits thereunder, the amount contributed to such systems, and a detailed statement of the allotments made by the Board, the income thereof, the requisitions made thereon, the administrative expenses of the Board and of the several approved State systems of health insurance, together with any other matters which the Board deems proper to report, including any recommendations it may desire to make.

PENALTIES

SEC. 8. Any person shall be guilty of a misdemeanor who—

(a) Willfully makes a false statement or representation to obtain any benefit, allotment, or payment under the provisions of this Act, either for himself or for any other person; or for any system of health insurance; or

(b) Violates any of the provisions of this Act or does any act prohibited by this Act, or fails, neglects, or refuses to perform any duty lawfully enjoined by this Act, or fails, neglects, or refuses to obey any lawful order given or made by the Board or any judgment or decree made by any court in connection with the provisions of this Act.

SAVING CLAUSE

SEC. 9. The Congress reserves the right to amend, alter, or repeal any provision of this Act; and no person, State, or State system of health insurance, or those entitled to benefits under any such system, shall be or be deemed to be vested with any property or other right by virtue of the enactment or operation of this Act.

SEPARABILITY OF PROVISIONS

SEC. 10. If any provision of this Act or the application thereof to any person or circumstances is held invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

APPROPRIATION

SEC. 11. The entire expenses of the Board in carrying out the provisions of this Act shall be paid out of the general revenue of the United States. The sum of $200,000, or so much thereof as may be necessary, is hereby appropriated for such purpose, out of any moneys in the Treasury not otherwise appropriated, for the fiscal year ending July 1, 1935, and the fiscal year ending July 1, 1936.

SHORT TITLE

SEC. 12. This Act shall be known and may be cited as the Federal Health Insurance Law.

EFFECTIVE DATE

SEC. 13. This Act shall take effect immediately.

[S. 3660, 76th Cong., 3d sess.]

A BILL To aid in the establishment and administration of State health insurance plans

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Social Security Act (Public Law Numbered 271, Seventy-fourth Congress, approved August 14, 1935) is amended by adding at the end thereof the following new title:

"TITLE XII—GRANTS TO STATES FOR HEALTH INSURANCE

"APPROPRIATION

"SEC. 1201. For the purpose of enabling each State to furnish medical, cash, and maternity benefits under State plans for health insurance, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1941, the sum of $50,000,000, and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Social Security Board established by title VII (hereinafter referred to as the 'Board'), State plans for health insurance.

"STATE PLANS FOR HEALTH INSURANCE

"SEC. 1202. A State plan for health insurance shall be approved only when the Board finds that it complies with the conditions, standards, and provisions contained in this section, as follows:

"(a) Premiums: (1) The fund out of which benefits are paid is created and maintained by regular premiums thereto paid by the State, employers and employees set according to the wage classes and equal to at least the weekly rates for each calendar week or any part thereof contained in the following schedule:

PREMIUM SCHEDULE

Wage class	When an employee's weekly wage rate is—	The employer's premium shall be—	The employee's premium shall be—	The State's premium shall be—
I	Under $15	$0.40	$0.10	$0.60
II	$15 to $19.99	.40	.20	.50
III	$20 to $24.99	.40	.30	.45
IV	$25 and over	.40	.40	.40

"(2) All premiums shall be paid into a single, State-wide fund to be held and administered by the State.

"(3) Employees' premiums shall be deducted by employers from their wages and remitted to the fund, and until so remitted shall be set apart and held by the employers as trust funds.

"(4) No agreement by an employee to pay any portion of the premium required to be paid by his employer shall be valid, and no employer shall make a deduction for such purpose from the wages of an employee, or in any other manner collect from an employee any portion of the premium required to be paid by his employer.

"(5) When an employee is employed by more than one employer in any calendar week, the employer who first employs him in that week shall be liable for paying the employer's premium and for deducting and remitting the employee's premium with respect to that week.

"(6) When one full premium has been paid with respect to a calendar week, or any part thereof, by an employee, his employer, and the State, no further premium shall be payable for that week either by the employee, any employer of the employee, or the State.

"(7) The State agency may, by special order, modify the provisions of paragraph (5) of subsection (a) in its application to employees whose work is of a casual or intermittent nature or who are employed by several employers and to their employers, and any such order may apply either generally or to any one or more particular trades or industries or branches thereof, or to any one or more particular employers or groupings of employers, and either generally or in any one or more particular localities. Any such order may make provision as to the payment of the employer's premium and as to the deduction and remission of the employee's premium in such manner, in such proportions and in respect of such periods as may be specified in the order, and for the apportionment among employers of the premiums payable by employers, notwithstanding any other provision in this title contained, and the State agency is empowered to modify and adapt the provisions of this title accordingly. No such order shall be made until notice thereof is given in advance, in a manner to be prescribed by the State agency, and an opportunity to be heard thereon is afforded to those interested in or affected by its proposed provisions.

"(8) The State agency shall make provision for the payment and collection of the premiums payable by employers and employees by means of adhesive or other stamps affixed to or impressed upon books or cards or otherwise; and for this purpose shall, through appropriate rules, regulate the manner, times, and conditions in, at, and under which such stamps are to be affixed or impressed, the entry in or upon books or cards of the particulars with respect to premiums paid and benefits furnished, the issue, sale, custody, production, and delivery up of books or cards, the replacement of those which have been lost, destroyed, or defaced, and all other incidental matters.

"(b) Cash benefits: (1) Cash benefits shall be paid to a person for each week of loss due to disability, after an uncompensated waiting period of not less than five nor more than seven consecutive full calendar days of loss due to such disability, according to the benefit classes and at weekly rates equal to at least those contained in the following schedule:

CASH BENEFIT SCHEDULE

Benefit class	When a person's weekly wage rate is—	Such person's weekly cash benefit amount shall be—			
		If he has no dependent	If he has one dependent	If he has two dependents	If he has three or more dependents
I	Under $15	$6.00	$7.50	$8.50	$9.50
II	$15 to $19.99	7.50	9.50	11.00	12.50
III	$20 to $24.99	9.00	11.00	13.00	14.50
IV	$25 and over	10.50	12.50	14.00	16.00

"(2) A person's benefit class shall be the same as his wage class in accordance with which the amount of the premium which he paid was determined as provided by the premium schedule contained in paragraph (1) of subsection (a).

"(3) Where a person has been in several wage classes and consequently paid varying premiums, the total amount of all premiums paid by him shall be averaged by dividing such total by the number of weeks for which such premiums were paid; his wage class shall then be deemed to be the one for which the aforesaid premium schedule fixes a premium nearest to the average amount so found and if such average amount falls exactly between two premiums as so fixed by the said schedule for two wage classes, respectively, his wage class shall be deemed to be the higher of the two; and his benefit class shall be fixed accordingly. A person's benefit class as determined when cash benefits are first payable within a period of fifty-two consecutive weeks shall remain fixed and shall not be altered during the balance of that period, but in the event of any change occurring during said period in the number of his dependents, his weekly cash-benefit amount shall correspondingly be changed as provided for that particular benefit class by the cash-benefits schedule.

"(4) Cash benefits shall be payable for at least twenty-six cumulated weeks of loss due to disability in each consecutive fifty-two weeks.

"(5) No cash benefits shall be payable to a person suffering disability for which he is entitled to receive or recover compensation or money benefits under any workmen's compensation act; nor shall cash benefits be payable to a person receiving old-age assistance, pension, or annuity under any Federal, State, or municipal act.

"(6) As a qualification for receiving cash benefits there shall be required not less than twenty nor more than twenty-five premiums within the fifty-two consecutive weeks preceding the day on which the claim for cash benefits is made or (in the alternative) not less than thirty-two nor more than forty such premiums within the one hundred and four consecutive weeks preceding said day.

"(c) Maternity benefits: (1) Regular cash maternity benefits shall be paid to a woman for not less than six weeks prior to the birth of a child and for not less than six weeks after the birth of a child, in amounts equal to the cash benefits which such woman would be entitled to receive for loss due to disability.

"(2) Regular cash maternity benefits shall not be paid for any part of the period for which it is payable during which the woman engages in any gainful occupation; nor shall such benefits be paid for any period for which the woman has received cash benefits.

"(3) To qualify for the regular cash maternity benefits, a woman shall be required to have not less than fifty nor more than sixty premiums within the one hundred and four consecutive weeks preceding the day on which the said benefit is to commence.

"(4) The regular cash maternity benefits shall be paid in full to a woman entitled to the same though her right to cash benefits for loss due to disability has terminated; nor shall the period during which she receives the regular cash maternity benefits be deemed part of the maximum period of twenty-six weeks of loss due to disability for which cash benefits may be paid.

"(5) On condition that prenatal care shall have been received as prescribed by the State agency each of the following shall be entitled to the sum of not less than $15 nor more than $25 on the birth of her child: A woman qualified to receive the cash maternity benefit; a wife of a man qualified under paragraph (6) of subsection (b); and a widow of a man who at the time of his death was so qualified, if the child be born within ten months of his death.

"(d) Medical benefits: (1) Medical benefits shall be provided for employees and their dependents.

"(2) Medical benefits shall be provided immediately on the occurrence of sickness or injury and to qualify for such benefits a person shall not be required to have more than four premiums or voluntary premiums or a combination of both within the three calendar months preceding the day on which the furnishing of medical benefits is to commence for him or any of his dependents.

"(3) Medical benefits need not be provided for any person in respect to any sickness or injury for which such person is entitled to medical treatment, care, or benefits under any workmen's compensation act nor in respect to any disease or condition for which medical treatment or care is furnished under the specific provisions of any other law, whether Federal, State, or municipal.

"(4) Medical benefits shall consist of not less than—

"(A) the services of a general medical practitioner (whether practicing alone or as a member of a group) at the office, home, hospital, or elsewhere, in preventive, diagnostic, and therapeutic treatment and care which shall include, under such regulations as the State agency may prescribe, immunizations and periodic physical examinations;

"(B) on the prescription of the general medical practitioner or of the specialist prescribed by the general medical practitioner, necessary general and special hospital treatment and care which shall include nursing and the other usual hospital services;

"(C) prenatal, maternity, and postnatal treatment and care at home or in a hospital;

"(D) on the prescription of the general medical practitioner, necessary services of a surgeon, diagnostician, medical, or other specialist (whether practicing alone or as a member of a group) at the office, home, hospital, or elsewhere;

"(E) on the prescription of the general medical practitioner, X-ray examinations and necessary services of laboratories and clinics;

"(F) the services of nurses outside of the hospital;

"(G) dental services for the relief of pain through surgical intervention.

"(5) If the State agency finds that the portion of the fund which is allocated to the cost of providing the medical benefits, in accordance with the provisions of paragraph (1) of subsection (h), is insufficient to provide all of the regular medical benefits as set forth in paragraph (4) of this subsection, it may provide only part or parts of such benefits and to such extent as it may deem feasible and its determinations in this respect may from time to time be reconsidered and altered by the State agency.

"(6) There shall be no limitation upon the said medical benefits except that the following may be imposed:

"(A) The benefit stipulated in clause (B) of paragraph (4) of subsection (d) need not be provided, in connection with any one sickness or injury, beyond a period of one hundred and eleven days, of which at least the first twenty-one days shall be without charge and the remaining ninety days may be at a charge of not more than 15 per centum of the cost of such benefit. Such benefit need not be furnished to any person sixty-five years of age or over for more than ninety days in any consecutive one hundred and four weeks.

"(B) In the event of a disabling sickness or injury, the benefits stipulated in clause (A) of paragraph (4) of subsection (d) need not be provided beyond a period of twenty-six weeks and the benefits stipulated in clauses (D) and (E) of said paragraph beyond a period of twelve weeks.

"(7) In the event an employee, because of disability or for any reason whatever, becomes unemployed or ceases being employed in an employment as defined in this title, the benefits stipulated in cause (A) of paragraph (4) of subsection (d) which he or any of his dependents may be receiving or may thereafter receive in connection with any one sickness or injury need not be provided beyond a period of twenty-six weeks and the benefits stipulated in clauses (D) and (E) of said paragraph beyond a period of twelve weeks: *Provided, however*, That if, prior to the expiration of four weeks after such employee becomes unemployed or ceases being employed in an employment subject to this title, the employee voluntarily insures himself for medical benefits, in accordance with the conditions stipulated in subsection (e) of this section, the said benefits stipulated in clauses (A), (D), and (E) of paragraph (4) of subsection (d) shall be provided with respect to said sickness or injury as long as he continues so to insure himself voluntarily.

"(8) Additional medical benefits other than those hereinbefore stipulated in paragraph (4) of subsection (d) may be furnished entirely at the expense of the fund or partly at the expense of the fund and partly at the expense of the persons receiving such additional medical benefits.

"(e) Voluntary insurance: Provision for voluntary insurance for medical benefits shall be made as follows:

"(1) Persons eligible: The following, not otherwise subject to the State plan, shall be entitled voluntarily to insure themselves for the medical benefits provided in subsection (d) for themselves, if they successfully pass such health examination as the State agency shall prescribe, and such of their dependents who successfully pass a similar examination, but no health examination shall be required of any person who within the preceding three years had to his credit not less than fifty-two premiums, nor of the dependents of any such person—

"(A) Any resident of the State, not suffering disability, whose net income from whatever source is $30 a week or less and who has not reached his sixty-fifth birthday.

"Such person shall for each calendar week pay into the fund a sum equal to three-fourths of the combined employer's and employee's premium as fixed for employees in the same wage class in the premium schedule contained in paragraph (1) of subsection (a).

"(B) Any resident of the State, not suffering disability, who within the preceding three years had to his credit not less than fifty-two premiums, or fifty-two voluntary premiums, or a combination of both, and whose net income from whatever source does not exceed $50 a week.

"Such person shall for each calendar week pay into the fund a sum equal to three-fourths of the combined employer's and employee's premium as fixed for employees in the same wage class in the premium schedule set forth in paragraph (1) of subsection (a).

"(C) Any resident of the State who within the preceding three years had to his credit not less than fifty-two premiums, or fifty-two voluntary premiums, or a combination of both, and who is unemployed though capable of and available for employment.

"Such person shall for each calendar week pay into the fund three-fourths of the combined employer's and employee's premium as fixed in the aforesaid premium schedule for employees in the same wage class which the State agency determines fairly represents his average weekly wages during the said preceding three years.

"(D) Any resident of the State who is receiving old-age or unemployment benefits or relief from any government or public officer or agency, if such officer or agency pays into the fund such amounts as the State agency may fix. The State agency shall, consistent with the purposes and aims of this title, fix amounts that will most equitably rate the risk and distribute the cost of the benefits.

"(2) All of the provisions contained in subsection (d) of this section with respect to qualifications, disqualification, extent of benefits, duration of benefits, and additional benefits shall apply to any person voluntarily insuring himself for the medical benefits pursuant to any of the clauses of paragraph (1) of this subsection and to his dependents and to the said benefits to which he and his dependents are entitled as if he were an employee subject to the State plan.

"(3) For each person voluntarily insuring himself for the medical benefits the State shall for each calendar week of such person's voluntary insurance pay into the fund an amount equal to three-fourths of the State's premium as fixed for employees in the same wage class in the premium schedule set forth in paragraph (1) of subsection (a).

"(4) All premiums provided for by the provisions of this subjection shall be paid or remitted to the State agency at regular and fixed intervals by means of a stamp system which the State agency shall prescribe, and shall promptly be paid over by the State agency to the treasurer of the State, who shall credit the same to the fund.

"(f) Administration: (1) The State plan shall be administered by a central State board, a State commissioner of health insurance, and by a State-wide system of local councils and local administrative officers. The State board shall be composed of the State commissioner of health or other State officer performing similar duties, The State commissioner of health insurance. and of eleven to fifteen members appointed by the Governor who shall be representatives of employers, of employees, and of the medical professions, and the hospitals which have agreed to furnish the medical benefits. The State board shall serve and function as a regulatory, policy-making, advisory, and supervisory body, but not as an administrative or executive body, and shall have the power to establish standards of administration for the State plan, to make all such rules and regulations as may be required for the administration thereof, and to amend and modify any of the said rules and regulations from time to time as may be found necessary or desirable.

"(2) The State commissioner of health insurance shall be the chief administrative and executive officer under the State plan and he shall have all the duties, powers, and authorities imposed and granted by the State plan or assigned to him by the State board. At representative of the State board and under its direction he shall supervise, direct, and control the administration and enforcement of the State plan throughout the State and all administrative and executive powers and duties needed for the proper administration and enforcement of the State plan shall be vested in the State commissioner of health insurance to be exercised by him within the rules and regulations and subject to the policies and in accordance with the principles established by the State board.

"(3) The State shall be divided and from time to time may be redivided into such number of local areas as may be found necessary and a local office shall be maintained in each of said local areas. For each local area there shall be a local finance manager and a local medical manager who shall be a physician. Local managers shall be full-time employees serving on an annual salary basis. In each local area, there shall be a local council. The local council shall be composed of one appointee who shall be representative of the professions engaged in furnishing the medical benefits, one appointee who shall be representative of employers, one appointee representative of employees, one appointee representativ of the hospitals which have agreed to furnish the medical benefits, the local finance manager who shall be the chairman, the local medical manager, and the local public health officer or his duly authorized deputy. The appointed members of the local council shall be designated by the State commissioner of health insurance with the approval of the State board. In addition to all other duties, powers, and authorities imposed and granted by the State plan, each local council within its local area shall, under the direction and subject to the review, approval, and control of the State board, supervise the collection of premiums, the payment of the cash and maternity benefits, the notices and proof of sickness, injury, and disability, and the furnishing of the medical benefits; prepare and publish lists of general medical and dental specialists, nurses, groups of such practitioners, pharmacists, hospitals, clinics, laboratories, and other persons and agencies within its local area who have agreed or with whom arrangements have been made to furnish the medical benefits; and distribute on a pro rata basis among the several practicioners or groups of such practitioners who have agreed to furnish the medical benefits those entitled to such benefits who after due notice have failed to make a selection or who have been refused by the practitioner or group of practictitioners whom they have selected.

"(4) The State plan shall have one or more local advisory committees in each local area, the members to be representative of employers, employees, the public, and the professions furnishing the medical benefits and to serve without salary but with allowances for actual and necessary expenses.

"(5) Excepting the members of the State board, the State commissioner of health, the representatives of the professions, of employers and of employees on the local councils and the members of the local advisory committees, all persons engaged in the administration of the State plan shall be appointed or employed and shall hold office on a merit-rating basis through open competitive examinations of a standard not inferior to that prescribed by the United States Civil Service.

"(6) The State agency shall be empowered to obtain from all employers and employees within the State, including those not subject to the provisions of the State plan, all such information as it may require in the administration of the State plan, to make reports on such administration as often and in such form as the same may be required by the Board and, from time to time, to make such other reports and such suggestions to the Board with respect to such administration and the operation of the State plan as it may think fit.

"(7) The State agency shall be empowered to submit to the Board in advance an estimate of the expenditures necessary to be incurred in the administration of the State plan.

"(8) Provision shall be made for the removal, after a hearing on written charges, of any general medical or dental practitioner, surgeon, other medical or dental specialist, nurse, group of such practitioners, pharmacists, hospital, clinic, laboratory, or other person or agency from the list of those who have agreed or with whom arrangements have been made to furnish medical benefits prepared and published by any local council when, in the opinion of the State board or the local council, the continued inclusion of such person, group, or agency would be prejudicial to the adequate, proper, or efficient furnishing of the medical benefits.

"(9) Provision shall be made for furnishing medical benefits to such persons entitled to the same under the State plan who are not residents of the State in any manner that seems to be most feasible, including the payment to such persons of sums equivalent to the cost of the medical benefits to which they are entitled.

"(10) The State agency shall be empowered to make inquiries into the causes and results of sickness and injuries, the sources of mortality and the effect of localities, employments, and other conditions upon the health of the persons entitled to the benefits provided by the State plan; to obtain, collect, preserve, and from time to time, publish such information relating to mortality, sickness, injury, and health as may be useful in the administration of the State plan or may contribute to the promotion of health or the security of life; to promote the health and safety of the persons entitled to the benefits provided by the State plan and to take such steps within its means as it may deem feasible and appropriate to reduce and prevent sickness, injury, and death among such persons; to cooperate with public-health officers and all other agencies, public and private, in the improvement of public health and sanitation, and in the promotion of public education in all matters pertaining to health.

"(1) Provision shall be made for fixing the manner of and making arrangements for remunerating general medical and dental practitioners, surgeons, medical, and other specialists, nurses, groups of such practitioners, pharmacists, hospitals, clinics, laboratories, and the other persons and agencies furnishing the medical benefits. Each local council shall be free to adopt such modes or combination of modes as in its opinion seems best, subject, however, to the supervision, direction, control, and approval of the State board.

"Any one of the following modes may be adopted for remunerating general medical and dental practitioners:

"(A) a salary system;

"(B) a per capita system whereunder payment will be based on the number of persons entitled to medical benefits included in the practitioner's list;

"(C) a fee system whereunder payment will be based on the extent and character of the treatment given and services rendered by the practitioner to persons entitled to medical benefits;

"(D) any combination or modification of the systems hereinabove stipulated;

"(E) a special arrangement with respect to doctors, dentists, or other professional persons practicing as a group.

"(12) No mode for remunerating general medical or dental practitioners shall be adopted for any local area without the consent of a majority of the general medical or dental practitioners, respectively, in that locality who have agreed to furnish medical benefits under the State plan.

"(13) Every general medical and dental practitioner, duly licensed to practice in the State (without discrimination against any school or mode of practice which is lawful in the State), and any number of such practitioners practicing as a group, shall have the right to be included in the list of those furnishing the medical benefits provided for by clauses (A) and (G) of paragraph (4) of subsection (d) prepared and published by the local council for each local area in which he or they may be engaging in practice, subject to being remunerated in the manner fixed for the local area in which the services are rendered and subject further to the power conferred upon the local councils and the State board, after hearing on written charges, to remove any practitioner or group of practitioners from any such list in the interest of the adequate, proper, or efficient furnishing of the said benefits.

"(14) Every person entitled to the medical benefits provided for by clauses (A) and (G) of paragraph (4) of subsection (d) shall have the right, in such form as the State agency shall prescribe, to select the general medical practitioner and the general dental practitioner or the group of such practitioners by whom he wishes to be attended and treated from the list of such practitioners or groups prepared and published by any local council irrespective of the local area in which such person may reside or be employed, subject to the consent of the practitioner or group so selected, and the right at any time to change the selection so made on such notice as the State agency may prescribe.

"(15) Any person claiming benefits shall in accordance with such rules as the State agency may prescribe register at the office in the local area in which he resides or in which he was last employed or in such other area as may be designated. After so registering, a person claiming benefits shall give notice of his continuing right to such benefits as often and in such manner as shall be prescribed.

"(16) Any person claiming cash or maternity benefits shall for the time that such benefits are claimed correctly report any wage-earning employment had during such time and any wages received for such employment, including employments not within the definition of this title, and shall make such reports in accordance with such rules as shall be prescribed.

"(17) Claims, complaints, and controversies with respect to contributions to the fund, the remuneration of those furnishing the medical benefits, the adequacy, quality, and extent of the medical benefits shall be determined by a local public officer employed on regular salary. A claimant and any other party affected shall be entitled to a hearing to be held before an independent referee and there shall be a right to an appeal from the determination of such referees to a State appeal board. The referees shall be under sole jurisdiction of the State appeal board, which shall be independent of the State agency. Hearings before referees and appeals shall be presented, heard, and determined in accordance with such rules and procedure as may be prescribed, but shall not be controlled by common law or statutory rules of evidence or by the technical or formal procedure employed in civil actions.

"(18) No agreement by an employee to waive any right or benefit under the State plan shall be valid; nor shall benefits be assigned, pledged, encumbered, released, or commuted, and such benefits shall be exempt from all claims of creditors and from levy, execution, and attachment or other remedy now or hereafter provided for recovery or collection of a debt, which exemption may not be waived.

"(19) Penalties shall be provided for any person who willfully makes a false statement or representation to obtain any benefit or payment under the provisions of the State plan, or to obtain payment or remuneration for services rendered or materials supplied in furnishing any of the benefits provided by the State plan, either for himself or for any other person, or to lower payments to be made to the fund; or who willfully refuses or fails to make any payment to the fund; or who fails to set apart and hold as a trust fund the amounts deducted from an employee's wages to pay the premiums required of such employee; or who refuses to allow the State agency or its authorized representative to inspect pay rolls or other records or documents relative to the enforcement and administration of the State plan; or who makes a deduction from the wages of any employee to pay any portion of the premium which an employer is required to make or in any other manner collects from an employee any portion of the premium required to be paid by an employer; or who violates any of the provisions of the State plan or does any act prohibited by the State plan, or fails, neglects, or refuses to perform any duty lawfully enjoined by the State plan, or fails, neglects, or refuses to obey any lawful order given or made by the State agency or any judgment or decree made by any court in connection with the provisions of the State plan.

"(20) The administration of the cash and maternity benefits provided for by the State plan shall, so far as it is practicable, be kept separate and apart from the administration of the medical benefits and all certificates of right to cash, maternity, and/or medical benefits shall be made by public officers who are duly licensed physicians. No physician, dentist, group of such practitioners, or other person or agency engaged in furnishing the medical benefits provided by the State plan, other than a public officer, shall be required to make any such certification.

"(g) Subrogation: (1) If any of the benefits provided by the State plan are paid or furnished in the event of sickness, injury, or disability to any person who by reason of such sickness, injury, or disability has a right or claim for compensation, benefits, or damages against his employer or any other person for causing such sickness, injury, or disability and for the damages resulting therefrom, whether under any workmen's compensation or employers' liability act, or otherwise under any statute, ordinance, code, regulation, or rule of law, the fund shall, to the extent of the said benefits so paid and the cost thereof so furnished, be entitled to reimbursement out of any sum or damages which said person receives by way of compensation or benefits or through suit, settlement, or judgment and the fund shall, to said extent, be subrogated to the said right or claim. Upon notice to the one against whom said right or claim exists or is asserted the amount to which the fund is so entitled by way of reimburement shall be a lien upon said right or claim and the said sum or damages paid or received thereunder.

"(2) If a person receiving the said benefits provided by the State plan for sickness, injury, or disability has such right or claim as described in the preceding paragraph and unreasonably refuses or neglects to take action or proceedings to enforce the same, it shall be lawful for the State agency to do either or both of the following:

"(A) at its own expense, to take such action or proceedings in the name and in behalf of the said person, in which case any sum recovered by settlement or judgment in excess of the claim for reimbursement given to the fund and the reasonable expenses of the action or proceedings shall be held by the State agency as trustee for the said person; and

"(B) to order the withholding of payment or the furnishing of any benefit to which the said person is entitled:

"In the event the State agency takes action or proceedings as aforesaid and fails therein, the fund alone shall be responsible for the costs and expenses as if it were claiming on its own account.

"(3) Nothing in the State plan contained shall be construed to prevent the prompt payment or furnishing of benefits to any person pending the settlement or determination of any such right or claim described in paragraph (1) of subsection (g) had or asserted by said person and any advance so made shall, without prejudice to any other method of recovery, be recoverable by deduction from or suspension of any benefits which may subsequently become payable or due to the said person.

"(4) If, pursuant to the last preceeding paragraph, advances are made to any person, the State agency may give notice thereof to the one against whom such a right or claim exists or is asserted and the latter may repay to the fund the amount and cost of the benefits so paid for furnished and such repayment shall, up to the amount thereof, be a full and valid discharge to him in respect of his liability to the said person.

"(h) The fund: (1) The fund created by the State plan shall consist of all premiums and money paid into and received by the fund; of property and securities acquired by and through the use of moneys belonging to the fund; and of interest and other income earned by the fund. One-fourth of all premiums and money paid into the fund, in accordance with the provisions of subsection (a) of this section, together with the interest and income earned thereon, shall be held and accounted for separately and the same shall be used to pay the cash and maternity benefits provided by the State plan, the entire cost of administering the said benefits, and such portion of all other expenditures as is properly allocable to the administration of the said benefits. The other three-fourths of the premiums and money paid into the fund in accordance with the provisions of subsection (a) of this section and all the premiums and money paid into the fund in accordance with paragraphs (1) and (3), of subsection (e) of this section, together with the interest and income earned thereon, shall be held and accounted for separately and the same shall be used to pay the cost of the medical benefits provided by the State plan, the entire cost of administering the said benefits, and such portions of all other expenditures as is properly allocable to the administration of the said benefits.

"(2) The State treasurer or other State officer performing similar duties shall be the custodian of the fund and all disbursements therefrom shall be paid by him upon vouchers of the State agency.

"(3) Any portion of the fund not needed for immediate use shall be deposited in the same manner and subject to all provisions of law with respect to the deposit of other State moneys; and all interest earned by such portion of the fund as may be so deposited shall be collected and placed to the credit of the fund.

"(4) Any of the surplus or reserves belonging to the fund may, by order of the State agency, approved by the State treasurer or other State officer performing similar duties, be invested in any obligations of the United States of America or in obligations of the State. The State agency may sell any of such certificates.

PAYMENT TO STATES

"SEC. 1203. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for health insurance, for each quarter, beginning with the quarter commencing July 1, 1940, (1) an amount, which shall be used exclusively for benefits, equal to one-half of the total of the premiums required to be paid by the State under subsection (a) of section 1202 and under paragraph (3) of subsection (e) of section 1202, and (2) 5 per centum of such amount, which shall be used for paying the costs of administering the State plan or for benefits, or both, and for no other purpose.

"(b) The method of computing and paying such amounts shall be as follows:

"(1) The Board shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of clause (1) of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the amount due from the State under subsection (a) of section 1202 and under paragraph (3) of subsection (e) of section 1202, and (B) such other investigation as the Board may find necessary.

"(2) The Board shall then certify to the Secretary of the Treasury the amount so estimated by the Board, (A) reduced or increased, as the case may be, by any sum by which it finds that its estimate for any prior quarter was greater or less than the amount which should have been paid to the State under clause (1) of subsection (a) for such quarter.

"(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Board, the amount so certified, increased by 5 per centum.

"OPERATION OF STATE PLANS

"SEC. 1204. In the case of any State plan for health insurance which has been approved by the Board, if the Board, after reasonable notice and opportunity for hearing to the State agency, finds that the State plan is not being maintained or the benefits provided thereunder are not being furnished in conformity to the provisions of section 1202 of this title or that the State plan is not being administered adequately, properly, or efficiently, the Board shall notify such State agency that further payments will not be made to the State until the Board is satisfied that the benefits and administration are provided in conformity with section 1202 of this title, and that there is no longer any such failure to comply. Until it is so satisfied it shall make no further certification to the Secretary of the Treasury with respect to such State.

"ADMINISTRATION

"SEC. 1205. There is hereby authorized to be appropriated for the fiscal year ending June 30, 1941, the sum of $250,000, for all necessary expenses of the Board in administering the provisions of this title.

"DEFINITIONS

"SEC. 1206. When used in this title—

"(a) The term 'State agency' means the central State Board charged with the administration of a State plan for health insurance.

"(b) The term 'State' includes the District of Columbia, Alaska, and Hawaii.

"(c) The term 'fund' means the health-insurance fund established by a State.

"(d) The term 'employer' means any person, partnership, firm, association, public or private corporation, the legal representatives of a deceased person, or the receiver, trustee, or successor of a person, partnership, firm, association, public or private corporation, including the State, municipal corporations, other governmental subdivisions, and all public agencies and authorities, who or whose agent or predecessor in interest has employed one or more persons in any employment subject to this title on each fifteen or more days within any calendar year. An employer shall be deemed subject to this title for all the purposes thereof on and after the first of the fifteen days on which such employment occurred, but his liability hereunder shall cease as of the 1st day of January of any calendar year on a written application made by him between the 1st and the 31st day of January of such year and on a finding that he has not employed one or more persons in any employment subject to this title on at least fifteen days within the preceding calendar year.

"Whenever any helper, assistant, or employee of an employer engages any other person in the work which said helper, assistant, or employee is doing for the employer, such employer shall for all purposes hereof be deemed the employer of such other person, whether such person is paid by the said helper, assistant, or employee, or by the employer, provided the employment has been with the knowledge, actual, constructive, or implied, of the employer.

"(e) The term 'employee' means any person employed for hire by an employer in an employment subject to this title, except any person employed under an express contract for a term of not less than one year at total wages for a year in excess of $1,500, and except further any person employed at nonmanual work receiving wages in excess of $30 a week.

"(f) The term 'employment' means any employment of an employee by an employer in which all or the greater part of the employee's work is performed within the State under any contract of hire, express or implied, oral or written, and shall include any trade, occupation, service, or profession in which any person may engage; except that for the purpose of this title it shall not include—

"(1) agricultural labor;

"(2) domestic service for an employer having less than three employees engaged in such service;

"(3) service by a minor who is actually in regular attendance during the daytime as a student in an institution of learning.

"(g) The term 'wages' means all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash. When an employment is of such character that the employees therein commonly receive gratuities from persons other than the employer, the amount or value of such gratuities shall be deemed and included as part of the wages paid by the employer.

"(h) The term 'premium' means the premium due to the fund under the provisions of this title for each calendar week or any part thereof during which an employee has had employment with an employer.

"(i) The term 'voluntary premium' means the premium which a person has paid into the fund for each calendar week during which he has voluntarily insured himself for medical benefits in accordance with the provisions of this title.

"(j) The term 'disability' means the inability of a person, because of sickness or injury, to continue at the work in which he is then engaged, though such work be in an employment not subject to this title; or, if a person be then unemployed, the inability, because of sickness or injury, to accept work for which he is reasonably fitted by training and experience, including work in employments not subject to this title: *Provided, however,* That in no case shall disability be deemed to exist if a person engages in any gainful occupation.

"(k) The term 'loss due to disability' means the total loss of wages or other remuneration because of disability.

"(l) The term 'a week of loss due to disability' means any six consecutive days of loss due to disability.

"(m) The term 'disabling sickness or injury' means any sickness or injury causing disability.

"(n) The term 'dependent' means the spouse, minor child, adopted child, step-

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[S. 489, 77th Cong., 1st sess.]

A BILL To aid in the establishment and administration of State health insurance plans

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Social Security Act (Public Law Numbered 271, Seventy-fourth Congress, approved August 14, 1935) is amended by adding at the end thereof the following new title:

"TITLE XII—GRANTS TO STATES FOR HEALTH INSURANCE

"APPROPRIATION

"SEC. 1201. For the purpose of enabling each State to furnish medical, cash, and maternity benefits under State plans for health insurance, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1941, the sum of $50,000,000, and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Social Security Board established by title VII (hereinafter referred to as the 'Board'), State plans for health insurance.

"STATE PLANS FOR HEALTH INSURANCE

"SEC. 1202. A State plan for health insurance shall be approved only when the Board finds that it complies with the conditions, standards, and provisions contained in this section, as follows:

"(a) Premiums: (1) The fund out of which benefits are paid is created and maintained by regular premiums thereto paid by the State, employers and employees set according to the wage classes and equal to at least the weekly rates for each calendar week or any part thereof contained in the following schedule:

PREMIUM SCHEDULE

Wage class	When an employee's weekly wage rate is—	The employer's premium shall be—	The employee's premium shall be—	The State's premium shall be—
I	Under $15	$0.40	$0.10	$0.60
II	$15 to $19.99	.40	.20	.50
III	$20 to $24.99	.40	.30	.45
IV	$25 and over	.40	.40	.40

"(2) All premiums shall be paid into a single State-wide fund to be held and administered by the State.

"(3) Employees' premiums shall be deducted by employers from their wages and remitted to the fund and until so remitted shall be set apart and held by the employers as trust funds.

"(4) No agreement by an employee to pay any portion of the premium required to be paid by his employer shall be valid, and no employer shall make a deduction for such purpose from the wages of an employee, or in any other manner collect from an employee any portion of the premium required to be paid by his employer.

"(5) When an employee is employed by more than one employer in any calendar week, the employer who first employs him in that week shall be liable for paying the employer's premium and for deducting and remitting the employee's premium with respect to that week.

"(6) When one full premium has been paid with respect to a calendar week, or any part thereof, by an employee, his employer, and the State, no further premium shall be payable for that week either by the employee, any employer of the employee, or the State.

"(7) The State agency may, by special order, modify the provisions of paragraph (5) of subsection (a) in its application to employees whose work is of a casual or intermittent nature or who are employed by several employers and to their employers, and any such order may apply either generally or to any one or more particular trades or industries or branches thereof, or to any one or more particular employers or groupings of employers, and either generally or in any one or more particular localities. Any such order may make provision as to the payment of the employer's premium and as to the deduction and remission of the employee's premium in such manner, in such proportions and in respect of such periods as may be specified in the order, and for the apportionment among employers of the premiums payable by employers, notwithstanding any other provision in this title contained and the State agency is empowered to modify and adapt the provisions of this title accordingly. No such order shall be made until notice thereof is given in advance, in a manner to be prescribed by the State agency, and an opportunity to be heard thereon is afforded to those interested in or affected by its proposed provisions.

"(8) The State agency shall make provision for the payment and collection of the premiums payable by employers and employees by means of adhesive or other stamps affixed to or impressed upon books or cards or otherwise and for this purpose shall, through appropriate rules, regulate the manner, times, and conditions in, at, and under which such stamps are to be affixed or impressed, the entry in or upon books or cards of the particulars with respect to premiums paid and benefits furnished the issue, sale, custody, production, and delivery up of books or cards, the replacement of those which have been lost, destroyed, or defaced, and all other incidental matters.

"(b) Cash benefits (1) Cash benefits shall be paid to a person for each week of loss due to disability, after an uncompensated waiting period of not less than five nor more than seven consecutive full calendar days of loss due to such disability, according to the benefit classes and at weekly rates equal to at least those contained in the following schedule:

CASH BENEFIT SCHEDULE

Benefit class	When a person's weekly wage rate is—	Such person's weekly cash benefit amount shall be—			
		If he has no dependent	If he has one dependent	If he has two dependents	If he has three or more dependents
I	Under $15	$6.00	$7.50	$8.50	$9.50
II	$15 to $19.99	7.50	9.50	11.00	12.50
III	$20 to $24.99	9.00	11.00	13.00	14.50
IV	$25 and over	10.50	12.50	14.00	16.00

"(2) A person's benefit class shall be the same as his wage class in accordance with which the amount of the premium which he paid was determined as provided by the premium schedule contained in paragraph (1) of subsection (a).

"(3) Where a person has been in several wage classes and consequently paid varying premiums, the total amount of all premiums paid by him shall be averaged by dividing such total by the number of weeks for which such premiums were paid; his wage class shall then be deemed to be the one for which the aforesaid premium schedule fixes a premium nearest to the average amount so found and if such average amount falls exactly between two premiums as so fixed by the said schedule for two wage classes, respectively, his wage class shall be deemed to be the higher of the two; and his benefit class shall be fixed accordingly. A person's benefit class as determined when cash benefits are first payable within a period of fifty-two consecutive weeks shall remain fixed and shall not be altered during the balance of that period, but in the event of any change occurring during said period in the number of his dependents, his weekly cash-benefit amount shall correspondingly be changed as provided for that particular benefit class by the cash-benefits schedule.

"(4) Cash benefits shall be payable for at least twenty-six cumulated weeks of loss due to disability in each consecutive fifty-two weeks.

"(5) No cash benefits shall be payable to a person suffering disability for which he is entitled to receive or recover compensation or money benefits under any workmen's compensation act; nor shall cash benefits be payable to a person receiving old-age assistance, pension, or annuity under any Federal, State, or municipal act.

"(6) As a qualification for receiving cash benefits there shall be required not less than twenty nor more than twenty-five premiums within the fifty-two consecutive weeks preceding the day on which the claim for cash benefits is made or (in the alternative) not less than thirty-two nor more than forty such premiums within the one hundred and four consecutive weeks preceding said day.

"(c) Maternity benefits: (1) Regular cash maternity benefits shall be paid to a woman for not less than six weeks prior to the birth of a child and for not less than six weeks after the birth of a child, in amounts equal to the cash benefits which such woman would be entitled to receive for loss due to disability.

"(2) Regular cash maternity benefits shall not be paid for any part of the period for which it is payable during which the woman engages in any gainful occupation: nor shall such benefits be paid for any period for which the woman has received cash benefits.

"(3) To qualify for the regular cash maternity benefits, a woman shall be required to have not less than fifty nor more than sixty premiums within the one hundred and four consecutive weeks preceding the day on which the said benefit is to commence.

"(4) The regular cash maternity benefits shall be paid in full to a woman entitled to the same though her right to cash benefits for loss due to disability has terminated; nor shall the period during which she receives the regular cash maternity benefits be deemed part of the maximum period of twenty-six weeks of loss due to disability for which cash benefits may be paid.

"(5) On condition that prenatal care shall have been received as prescribed by the State agency each of the following shall be entitled to the sum of not less than $15 nor more than $25 on the birth of her child: A woman qualified to receive the cash maternity benefit; a wife of a man qualified under paragraph (6) of subsection (b); and a widow of a man who at the time of his death was so qualified; if the child be born within ten months of his death.

"(d) Medical benefits: (1) Medical benefits shall be provided for employees and their dependents.

"(2) Medical benefits shall be provided immediately on the occurrence of sickness or injury and to qualify for such benefits a person shall not be required to have more than four premiums or voluntary premiums or a combination of both within the three calendar months preceding the day on which the furnishing of medical benefits is to commence for him or any of his dependents.

"(3) Medical benefits need not be provided for any person in respect to any sickness or injury for which such person is entitled to medical treatment, care, or benefits under any workmen's compensation act nor in respect to any disease or condition for which medical treatment or care is furnished under the specific provisions of any other law, whether Federal, State, or municipal.

"(4) Medical benefits shall consist of not less than—

"(A) the services of a general medical practitioner (whether practicing alone or as amember of a group) at the office, home, hospital, or elsewhere, in preventive, diagnostic, and therapeutic treatment and care which shall include, under such regulations as the State agency may prescribe, immunizations and periodic physical examinations;

"(B) on the prescription of the general medical practitioner or of the specialist prescribed by the general medical practitioner, necessary general and special hospital treatment and care which shall include nursing and the other usual hospital services;

"(C) prenatal, maternity, and postnatal treatment and care at home or in a hospital;

"(D) on the prescription of the general medical practitioner, necessary services of a surgeon, diagnostician, medical, or other specialist (whether practicing alone or as a member of a group) at the office, home, hospital, or elsewhere;

"(E) on the prescription of the general medical practiioner, X-ray examinations and necessary services of laboratories and clinics;

"(F) the services of nurses outside of the hospital;

"(G) dental services for the relief of pain through surgical intervention.

"(5) If the State agency finds that the portion of the fund which is allocated to the cost of providing the medical benefits, in accordance with the provisions of paragraph (1) of subsection (h), is insufficient to provide all of the regular medical benefits as set forth in paragraph (4) of this subsection, it may provide only part or parts of such benefits and to such extent as it may deem feasible and its determination in this respect may from time to time be reconsidered and altered by the State agency.

"(6) There shall be no limitation upon the said medical benefits except that the following may be imposed:

"(A) The benefit stipulated in clause (B) of paragraph (4) of subsection (d) need not be provided, in connection with any one sickness or injury, beyond a period of one hundred and eleven days, of which at least the first twenty-one days shall be without charge and the remaining ninety days may be at a charge of not more than 15 per centum of the cost of such benefit. Such benefit need not be furnished to any person sixty-five years of age or over for more than ninety days in any consecutive one hundred and four weeks.

"(B) In the event of a disabling sickness or injury the benefits stipulated in clause (A) of paragraph (4) of subsection (d) need not be provided beyond a period of twenty-six weeks and the benefits stipulated in clauses (D) and (E) of said paragraph beyond a period of twelve weeks.

"(7) In the event an employee, because of disability or for any reason whatever, becomes unemployed or ceases being employed in an employment as defined in this title, the benefits stipulated in clause (A) of paragraph (4) of subsection (d) which he or any of his dependents may be receiving or may thereafter receive in connection with any one sickness or injury need not be provided beyond a period of twenty-six weeks and the benefits stipulated in clauses (D) and (E) of said paragraph beyond a period of twelve weeks: *Provided, however,* That if, prior to the expiration of four weeks after such employee becomes unemployed or ceases being employed in an employment subject to this title, the employee voluntarily insures himself for medical benefits, in accordance with the conditions stipulated in subsection (e) of this section, the said benefits stipulated in clauses (A), (D), and (E) of paragraph (4) of subsection (d) shall be provided with respect to said sickness or injury as long as he continues so to insure himself voluntarily.

"(8) Additional medical benefits other than those hereinbefore stipulated in paragraph (4) of subsection (d) may be furnished entirely at the expense of the fund or partly at the expense of the fund and partly at the expense of the persons receiving such additional medical benefits.

"(e) Voluntary insurance: Provision for voluntary insurance for medical benefits shall be made as follows:

"(1) Persons eligible: The following, not otherwise subject to the State plan, shall be entitled voluntarily to insure themselves for the medical benefits provided in subsection (d) for themselves, if they successfully pass such health examination as the State agency shall prescribe, and such of their dependents who successfully pass a similar examination, but no health examination shall be required of any person who within the preceding three years had to his credit not less than fifty-two premiums, nor of the dependents of any such person—

"(A) Any resident of the State, not suffering disability, whose net income from whatever source is $30 a week or less and who has not reached his sixty-fifth birthday.

"Such person shall for each calendar week pay into the fund a sum equal to three-fourths of the combined employer's and employee's premium as fixed for employees in the same wage class in the premium schedule contained in paragraph (1) of subsection (a).

"(B) Any resident of the State, not suffering disability, who within the preceding three years had to his credit not less than fifty-two premiums, or fifty-two voluntary premiums, or a combination of both, and whose net income from whatever source does not exceed $50 a week.

"Such person shall for each calendar week pay into the fund a sum equal to three-fourths of the combined employer's and employee's premium as fixed for employees in the same wage class in the premium schedule set forth in paragraph (1) of subsection (a).

"(C) Any resident of the State who within the preceding three years had to his credit not less than fifty-two premiums, or fifty-two voluntary premiums, or a combination of both, and who is unemployed though capable of and available for employment.

"Such person shall for each calendar week pay into the fund three-fourths of the combined employer's and employee's premium as fixed in the aforesaid premium schedule for employees in the same wage class which the State agency determines fairly represents his average weekly wages during the said preceding three years.

"(D) Any resident of the State who is receiving old-age or unemployment benefits or relief from any governmental or public officer or agency, if such officer or agency pays into the fund such amounts as the State agency may fix. The State agency shall, consistent with the purposes and aims of this title, fix amounts that will most equitably rate the risk and distribute the cost of the benefits.

"(2) All of the provisions contained in subsection (d) of this section with respect to qualifications, disqualifications, extent of benefits, duration of benefits, and additional benefits shall apply to any person voluntarily insuring himself for the medical benefits pursuant to any of the clauses of paragraph (1) of this subsection and to his dependents and to the said benefits to which he and his dependents are entitled as if he were an employee subject to the State plan.

"(3) For each person voluntarily insuring himself for the medical benefits the State shall for each calendar week of such person's voluntary insurance pay into the fund an amount equal to three-fourths of the State's premium as fixed for employees in the same wage class in the premium schedule set forth in paragraph (1) of subsection (a).

"(4) All premiums provided for by the provisions of this subsection shall be paid or remitted to the State agency at regular and fixed intervals by means of a stamp system which the State agency shall prescribe, and shall promptly be paid over by the State agency to the treasurer of the State, who shall credit the same to the fund.

"(f) Administration: (1) The State plan shall be administered by a central State board, a State commissioner of health insurance, and by a State-wide system of local councils and local administrative officers. The State board shall be composed of the State commissioner of health or other State officer performing similar duties, the State commissioner of health insurance, and of eleven to fifteen members appointed by the Governor who shall be representatives of employers, of employees, and of the medical professions, and the hospitals which have agreed to furnish the medical benefits. The State board shall serve and function as a regulatory, policy-making, advisory, and supervisory body, but not as an administrative or executive body, and shall have the power to establish standards of administration for the State plan, to make all such rules and regulations as may be required for the administration thereof, and to amend and modify any of the said rules and regulations from time to time as may be found necessary or desirable.

"(2) The State commissioner of health insurance shall be the chief administrative and executive officer under the State plan and he shall have all the duties, powers, and authorities imposed and granted by the State plan or assigned to him by the State board. As representative of the State board and under its direction he shall supervise, direct, and control the administration and enforcement of the State plan throughout the State and all administrative and executive powers and duties needed for the proper administration and enforcement of the State plan shall be vested in the State commissioner of health insurance to be exercised by him within the rules and regulations and subject to the policies and in accordance with the principles established by the State board.

"(3) The State shall be divided and from time to time may be redivided into such number of local areas as may be found necessary and a local office shall be maintained in each of said local areas. For each local area there shall be a local finance manager and a local medical manager who shall be a physician. Local managers shall be full-time employees serving on an annual salary basis. In each local area, there shall be a local council. The local council shall be composed of one appointee who shall be representative of the professions engaged in furnishing the medical benefits, one appointee who shall be representative of employers, one appointee representative of employees, one appointee representative of the hospitals which have agreed to furnish the medical benefits, the local finance manager who shall be the chairman, the local medical manager, and the local public health officer or his duly authorized deputy The appointed members of the local council shall be designated by the State commissioner of health insurance with the approval of the State board. In addition to all other duties, powers, and authorities imposed and granted by the State plan, each local council within its local area shall, under the direction and subject to the review, approval, and control of the State board, supervise the collection of premiums, the payment of the cash and maternity benefits, the notices and proof of sickness, injury, and disability, and the furnishing of the medical benefits; prepare and publish lists of general medical and dental specialists, nurses, groups of such practitioners, pharmacists, hospitals, clinics, laboratories, and other persons and agencies within its local area who have agreed or with whom arrangements have been made to furnish the medical benefits; and distribute on a pro rata basis among the several practitioners or groups of such practitioners who have agreed to furnish the medical benefits those entitled to such benefits who after due notice have failed to make a selection or who have been refused by the practitioner or group of practitioners whom they have selected.

"(4) The State plan shall have one or more local advisory committees in each local area, the members to be representative of employers, employees, the public, and the professions furnishing the medical benefits and to serve without salary but with allowances for actual and necessary expenses.

"(5) Excepting the members of the State board, the State commissioner of health, the representatives of the professions, of employers and of employees on the local councils and the members of the local advisory committees, all persons engaged in the administration of the State plan shall be appointed or employed and shall hold office on a merit-rating basis through open competitive examinations of a standard not inferior to that prescribed by the United States Civil Service.

"(6) The State agency shall be empowered to obtain from all employers and employees within the State, including those not subject to the provisions of the State plan, all such information as it may require in the administration of the State plan, to make reports on such administration as often and in such form as the same may be required by the Board and, from time to time, to make such other reports and such suggestions to the Board with respect to such administration and the operation of the State plan as it may think fit.

"(7) The State agency shall be empowered to submit to the Board in advance an estimate of the expenditures necessary to be incurred in the administration of the State plan.

"(8) Provision shall be made for the removal, after a hearing on written charges, of any general medical or dental practitioner, surgeon, other medical or dental specialist, nurse, group of such practitioners, pharmacist, hospital, clinic, laboratory, or other person or agency from the list of those who have agreed or with whom arrangements have been made to furnish medical benefits prepared and published by any local council when, in the opinion of the State board or the local council, the continued inclusion of such person, group, or agency would be prejudicial to the adequate, proper, or efficient furnishing of the medical benefits.

"(9) Provision shall be made for furnishing medical benefits to such persons entitled to the same under the State plan who are not residents of the State in any manner that seems to be most feasible, including the payment to such persons of sums equivalent to the cost of the medical benefits to which they are entitled.

"(10) The State agency shall be empowered to make inquiries into the causes and results of sickness and injuries, the sources of mortality and the effect of localities, employments, and other conditions upon the health of the persons entitled to the benefits provided by the State plan; to obtain, collect, preserve, and from time to time, publish such information relating to mortality, sickness, injury, and health as may be useful in the administration of the State plan or may contribute to the promotion of health or the security of life; to promote the health and safety of the persons entitled to the benefits provided by the State plan and to take such steps within its means as it may deem feasible and appropriate to reduce and prevent sickness, injury, and death among such persons; to cooperate with public-health officers and all other agencies, public and private, in the improvement of public health and sanitation, and in the promotion of public education in all matters pertaining to health.

"(11) Provision shall be made for fixing the manner of and making arrangements for remunerating general medical and dental practitioners, surgeons, medical and other specialists, nurses, groups of such practitioners, pharmacists, hospitals, clinics, laboratories, and the other persons and agencies furnishing the medical benefits. Each local council shall be free to adopt such modes or combination of modes as in its opinion seems best, subject, however, to the supervision, direction, control, and approval of the State board.

"Any one of the following modes may be adopted for remunerating general medical and dental practitioners:

"(A) a salary system;

"(B) a per capita system whereunder payment will be based on the number of persons entitled to medical benefits included in the practitioner's list;

"(C) a fee system whereunder payment will be based on the extent and character of the treatment given and services rendered by the practitioner to persons entitled to medical benefits;

"(D) any combination or modification of the systems hereinabove stipulated;

"(E) a special arrangement with respect to doctors, dentists or other professional persons practicing as a group.

"(12) No mode for remunerating general medical or dental practitioners shall be adopted for any local area without the consent of a majority of the general medical or dental practitioners, respectively, in that locality who have agreed to furnish medical benefits under the State plan.

"(13) Every general medical and dental practitioner, duly licensed to practice in the State (without discrimination against any school or mode of practice which is lawful in the State), and any number of such practitioners practicing as a group, shall have the right to be included in the list of those furnishing the medical benefits provided for by clauses (A) and (G) of paragraph (4) of subsection (d) prepared and published by the local council for each local area in which he or they may be engaging in practice, subject to being remunerated in the manner fixed for the local area in which the services are rendered and subject further to the power conferred upon the local councils and the State board, after hearing on written charges, to remove any practitioner or group of practitioners from any such list in the interest of the adequate, proper, or efficient furnishing of the said benefits.

"(14) Every person entitled to the medical benefits provided for by clauses (A) and (G) of paragraph (4) of subsection (d) shall have the right, in such form as the State agency shall prescribe, to select the general medical practitioner and the general dental practitioner or the group of such practitioners by whom he wishes to be attended and treated from the list of such practitioners or groups prepared and published by any local council irrespective of the local area in which such person may reside or be employed, subject to the consent of the practitioner or group so selected, and the right at any time to change the selection so made on such notice as the State agency may prescribe.

"(15) Any person claiming benefits shall in accordance with such rules as the State agency may prescribe register at the office in the local area in which he resides or in which he was last employed or in such other area as may be designated. After so registering a person claiming benefits shall give notice of his continuing right to such benefits as often and in such manner as shall be prescribed.

"(16) Any person claiming cash or maternity benefits shall for the time that such benefits are claimed correctly report any wage-earning employment had during such time and any wages received for such employment, including employments not within the definition of this title, and shall make such reports in accordance with such rules as shall be prescribed.

"(17) Claims, complaints, and controversies with respect to contributions to the fund, the remuneration of those furnishing the medical benefits, the adquacy, quality, and extent of the medical benefits shall be determined by a local public officer employed on regular salary. A claimant and any other party affected shall be entitled to a hearing to be held before an independent referee and there shall be a right to an appeal from the determination of such referees to a State appeal board. The referees shall be under sole jurisdiction of the State appeal board, which shall be independent of the State agency. Hearings before referees and appeals shall be presented, heard, and determined in accordance with such rules and procedure as may be prescribed, but shall not be controlled by common law or statutory rules of evidence or by the technical or formal procedure employed in civil actions.

"(18) No agreement by an employee to waive any right or benefit under the State plan shall be valid; nor shall benefits be assigned, pledged, encumbered, released, or commuted, and such benefits shall be exempt from all claims of creditors and from levy, execution, and attachment or other remedy now or hereafter provided for recovery or collection of a debt, which exemption may not be waived.

"(19) Penalties shall be provided for any person who willfully makes a false statement or representation to obtain any benefit or payment under the provisions of the State plan, or to obtain payment or remuneration for services rendered or materials supplied in furnishing any of the benefits provided by the State plan, either for himself or for any other person, or to lower payments to be made to the fund; or who willfully refuses or fails to make any payment to the fund; or who fails to set apart and hold as a trust fund the amounts deducted from an employee's wages to pay the premiums required of such employee; or who refuses to allow the State agency or its authorized representative to inspect pay rolls or other records or documents relative to the enforcements and administration of the State plan; or who makes a deduction from the wages of any employee to pay any portion of the premium which an employer is required to make or in any other manner collects from an employee any portion of the premium required to be paid by an employer; or who violates any of the provisions of the State plan or does any act prohibited by the State plan, or fails, neglects, or refuses to perform any duty lawfully enjoined by the State plan, or fails, neglects, or refuses to obey any lawful order given or made by the State agency or any judgment or decree made by any court in connection with the provisions of the State plan.

"(20) The administration of the cash and maternity benefits provided for by the State plan shall, so far as it is practicable, be kept separate and apart from the administration of the medical benefits and all certificates of right to cash, maternity, and/or medical benefits shall be made by public officers who are duly licensed physicians. No physician, dentist, group of such practitioners, or other person or agency engaged in furnishing the medical benefits provided by the State plan, other than a public officer, shall be required to make any such certification.

"(g) Subrogation: (1) If any of the benefits provided by the State plan are paid or furnished in the event of sickness, injury, or disability to any person who by reason of such sickness, injury, or disability has a right or claim for compensation, benefits, or damages against his employer or any other person for causing such sickness, injury, or disability and for the damages resulting therefrom, whether under any workmen's compensation or employers' liability act, or otherwise under any statute, ordinance, code, regulation, or rule of law, the fund shall, to the extent of the said benefits so paid and the cost thereof so furnished, be entitled to reimbursement out of any sum or damages which said person receives by way of compensation or benefits or through suit, settlement, or judgment and the fund shall, to said extent, be subrogated to the said right or claim. Upon notice to the one against whom said right or claim exists or is asserted the amount to which the fund is so entitled by way of reimbursement shall be a lien upon said right or claim and the said sum or damages paid or received thereunder.

"(2) If a person receiving the said benefits provided by the State plan for sickness, injury, or disability has such right or claim as described in the preceding paragraph and unreasonably refuses or neglects to take action or proceedings to enforce the same, it shall be lawful for the State agency to do either or both of the following:

"(A) at its own expense, to take such action or proceedings in the name and in behalf of the said person, in which case any sum recovered by settlement or judgment in excess of the claim for reimbursement given to the fund and the reasonable expenses of the action or proceedings shall be held by the State agency as trustee for the said person; and

"(B) to order the withholding of payment or the furnishing of any benefit to which the said person is entitled.

"In the event the State agency takes action or proceedings as aforesaid and fails therein, the fund alone shall be responsible for the costs and expenses as if it were claiming on its own account.

"(3) Nothing in the State plan contained shall be construed to prevent the prompt payment or furnishing of benefits to any person pending the settlement or determination of any such right or claim described in paragraph (1) of subsection (g) had or asserted by said person and any advance so made shall, without prejudice to any other method of recovery, be recoverable by deduction from or suspension of any benefits which may subsequently become payable or due to the said person.

"(4) If, pursuant to the last preceding paragraph, advances are made to any person, the State agency may give notice thereof to the one against whom such a right or claim exists or is asserted and the latter may repay to the fund the amount and cost to the benefits so paid or furnished and such repayment shall, up to the amount thereof, be a full and valid discharge to him in respect of his liability to the said person.

"(h) The fund: (1) The fund created by the State plan shall consist of all premiums and money paid into and received by the fund; of property and securities acquired by and through the use of moneys belonging to the fund; and of interest and other income earned by the fund. One-fourth of all premiums and money paid into the fund, in accordance with the provisions of subsection (a) of this section, together with the interest and income earned thereon, shall be held and accounted for separately and the same shall be used to pay the cash and maternity benefits provided by the State plan, the entire cost of administering the said benefits, and such portion of all other expenditures as is properly allocable to the administration of the said benefits. The other three-fourths of the premiums and money paid into the fund in accordance with the provisions of subsection (a) of this section and all the premiums and money paid into the fund in accordance with paragraphs (1) and (3), of subsection (e) of this section, together with the interest and income earned thereon, shall be held and accounted for separately and the same shall be used to pay the cost of the medical benefits provided by the State plan, the entire cost of administering the said benefits, and such portion of all other expenditures as is properly allocable to the administration of the said benefits.

"(2) The State treasurer or other State officer performing similar duties shall be the custodian of the fund and all disbursements therefrom shall be paid by him upon vouchers of the State agency.

"(3) Any portion of the fund not needed for immediate use shall be deposited in the same manner and subject to all provisions of law with respect to the deposit of other State moneys; and all interest earned by such portion of the fund as may be so deposited shall be collected and placed to the credit of the fund.

"(4) Any of the surplus or reserves belonging to the fund may, by order of the State agency, approved by the State treasurer or other State officer performing similar duties, be invested in any obligations of the United States of America or in obligations of the State. The State agency may sell any of such certificates.

"PAYMENT TO STATES

"SEC. 1203. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for health insurance, for each quarter, beginning with the quarter commencing July 1, 1940, (1) an amount, which shall be used exclusively for benefits, equal to one-half of the total of the premiums required to be paid by the State under subsection (a) of section 1202 and under paragraph (3) of subsection (e) of section 1202, and (2) 5 per centum of such amount, which shall be used for paying the costs of administering the State plan or for benefits, or both, and for no other purpose.

"(b) The method of computing and paying such amounts shall be as follows:

"(1) The Board shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of clause (1) of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the amount due from the State under subsection (a) of section 1202 and under paragraph (3) of subsection (e) of section 1202, and (B) such other investigation as the Board may find necessary.

"(2) The Board shall then certify to the Secretary of the Treasury the amount so estimated by the Board, (A) reduced or increased, as the case may be, by any sum by which it finds that its estimate for any prior quarter was greater or less than the amount which should have been paid to the State under clause (1) of subsection (a) for such quarter.

"(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Board, the amount so certified, increased by 5 per centum.

"OPERATION OF STATE PLANS

"SEC. 1204. In the case of any State plan for health insurance which has been approved by the Board, if the Board, after reasonable notice and opportunity for hearing to the State agency, finds that the State plan is not being maintained or the benefits provided thereunder are not being furnished in conformity to the provisions of section 1202 of this title or that the State plan is not being administered adequately, properly, or efficiently, the Board shall notify such State agency that further payments will not be made to the State until the Board is satisfied that the benefits and administration are provided in conformity with section 1202 of this title, and that there is no longer any such failure to comply. Until it is so satisfied it shall make no further certification to the Secretary of the Treasury with respect to such State.

"ADMINISTRATION

"SEC. 1205. There is hereby authorized to be appropriated for the fiscal year ending June 30, 1941, the sum of $250,000, for all necessary expenses of the Board in administering the provisions of this title.

"DEFINITIONS

"SEC. 1206. When used in this title—

"(a) The term 'State agency' means the central State board charged with the administration of a State plan for health insurance.

"(b) The term 'State' includes the District of Columbia, Alaska, and Hawaii.

"(c) The term 'fund' means the health-insurance fund established by a State.

"(d) The term 'employer' means any preson, partnership, firm, association, public or private corporation, the legal representatives of a deceased person, or the receiver, trustee, or successor of a person, partnership, firm, association, public or private corporation, including the State, municipal corporations, other governmental subdivisions, and all public agencies and authorities, who or whose agent or predecessor in interest has employed one or more persons in any employment subject to this title on each fifteen or more days within any calendar year. An employer shall be deemed subject to this title for all the purposes thereof on and after the first of the fifteen days on which such employment occurred, but his liability hereunder shall cease as of the 1st day of January of any calendar year on a written application made by him between the 1st and the 31st day of January of such year and on a finding that he has not employed one or more persons in any employment subject to this title on at least fifteen days within the preceding calendar year.

"Whenever any helper, assistant, or employee of an employer engages any other person in the work which said helper, assistant, or employee is doing for the employer, such employer shall for all purposes hereof be deemed the employer of such other person, whether such person is paid by the said helper, assistant, or employee, or by the employer, provided the employment has been with the knowledge, actual, constructive, or implied, of the employer.

"(e) The term 'employee' means any person employed for hire by an employer in an employment subject to this title, except any person employed under an express contract for a term of not less than one year at total wages for a year in excess of $1,500, and except further any person employed at nonmanual work receiving wages in excess of $30 a week.

"(f) The term 'employment' means any employment of an employee by an employer in which all or the greater part of the employee's work is performed within the State under any contract of hire, express, or implied, oral or written, and shall include any trade, occupation, service, or profession in which any person may engage; except that for the purpose of this title it shall not include—

"(1) agricultural labor;

"(2) domestic service for an employer having less than three employees engaged in such service;

"(3) service by a minor who is actually in regular attendance during the daytime as a student in an institution of learning.

"(g) The term 'wages' means all remuneration for employment, including the cash value of all remuneration paid in any medium other than cash. When an employment is of such character that the employees therein commonly receive gratuities from persons other than the employer, the amount or value of such gratuities shall be deemed and included as part of the wages paid by the employer.

"(h) The term 'premium' means the premium due to the fund under the provisions of this title for each calendar week or any part thereof during which an employee has had employment with an employer.

"(i) The term 'voluntary premium' means the premium which a person has paid into the fund for each calendar week during which he has voluntarily insured himself for medical benefits in accordance with the provisions of this title.

"(j) The term 'disability' means the inability of a person, because of sickness or injury, to continue at the work in which he is then engaged, though such work be in an employment not subject to this title; or, if a person be then unemployed, the inability, because of sickness or injury, to accept work for which he is reasonably fitted by training and experience, including work in employments not subject to this title: *Provided, however,* That in no case shall disability be deemed to exist if a person engages in any gainful occupation.

"(k) The term 'loss due to disability' means the total loss of wages or other remuneration because of disability.

"(l) The term 'a week of loss due to disability' means any six consecutive days of loss due to disability.

"(m) The term 'disabling sickness or injury' means any sickness or injury causing disability.

"(n) The term 'dependent' means the spouse, minor child, adopted child, stepchild, or grandchild of a person and deriving main support from such person."

[S. 2963, 76th Cong., 1st sess.]

A BILL To provide health insurance to certain workers in severe economic distress

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Insurance Act of 1939."

SEC. 2. The Social Security Act is amended by adding at the end thereof the following new title:

"TITLE XII—HEALTH INSURANCE

"APPROPRIATION

"SEC. 1201. For the purpose of assisting qualified individuals to receive medical services when they require such care but are without means, the Secretary of the Treasury is directed to pay each month from the "Old-Age Reserve Account" the amount estimated by him and by the Chairman of the Social Security Board which will be expended during the month by the Social Security Board and the Treasury Department for the administration of this title.

"QUALIFIED INDIVIDUALS

"SEC. 1202. An individual shall be qualified for health-insurance payments under this title if—

"(a) he has been registered as unemployed for at least fifteen consecutive weeks at a public employment office or other agency approved by the Board; and

"(b) he is not receiving an old-age benefit payment under title II; and

"(c) he has been paid, after December 31, 1936, not less than $5,000 in total wages (as defined in section 210 (a) with respect to employment (as defined in section 210 (b)); and

"(d) he has been paid such wages, with respect to such employment on some three days after December 31, 1936, and before he attained the age of sixty-five, each day being in a different calendar year; and

"(e) he has filed with the Social Security Board (1) an application for health-insurance benefits, (2) a bill for medical or hospital services rendered to him, and (3) the sworn affidavit of the attending doctor or of the medical supervisor of a hospital furnishing assistance to him, that the applicant received medical or hospital treatment from such doctor or such hospital and that the bill rendered is a reasonable charge for such services.

"HEALTH-INSURANCE BENEFIT PAYMENTS

"SEC. 1203. (a) Every qualified individual shall be entitled in any year, upon approval of his application by the Social Security Board, to have forwarded to the doctor or hospital furnishing him with medical or hospital services, in part or full payment, for such services a sum equal to all or to any part of the health-insurance benefit to which such individual is entitled for such year. The health-insurance benefit to which a qualified individual is entitled for any year shall be equal to one-fifth of 1 per centum of his total wages, except that such benefit shall not be in excess of $25 for any year and the total of all such benefits for any individual shall not be in excess of $100.

"(b) If the Board finds at any time that more or less than the correct amount has theretofore been paid in behalf of any individual under this section, then, under regulations made by the Board, proper adjustments shall be made in connection with subsequent payments under this section in behalf of the same individual.

"REGULATIONS

"SEC. 1204. (a) The Board shall have full power and authority to make rules and regulations and to establish procedures not inconsistent with the provisions of this title which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.

"(b) The Board is directed to make findings of fact, and decisions as to the rights of any individual applying for benefits under this title.

"(c) The Social Security Board shall provide for opportunity for a fair hearing before an impartial tribunal for individuals whose claims for health-insurance benefits are denied.

"METHOD OF MAKING PAYMENTS

"SEC. 1205. Upon approval of an application and the bill for medical or hospital services submitted therewith, the Board shall certify to the Secretary of the Treasury the name and address of the doctor or hospital entitled to be paid for medical or hospital services given to a qualified individual, the name and address of such qualified individual, the amount of such payment, and the time at which it should be made, and the Secretary of the Treasury through the Division of Disbursement of the Treasury Department, and prior to audit or settlement by the General Accounting Office, shall make payment in accordance with the certification by the Board.

"PENALTIES

"SEC. 1206. (a) Whoever in any application for any payment under this title or in any document in connection with such application makes any false statement as to any material fact, knowing such statement to be false, shall be fined not more than $1,000 or imprisoned for not more than one year, or both.

"(b) Any qualified individual participating in any such false statement shall lose all further rights to health-insurance benefit payments.

"(c) Any doctor participating in any such false statement shall be reported by the Board to the medical authority which issues and revokes licenses to practice medicine in his State.

"DEFINITIONS

"(a) The term 'hospital,' when used in this title, includes health, diagnostic, and treatment centers, institutions, and related facilities, administered by a person licensed to practice medicine in that State and which operates on a nonprofit basis.

"(b) The term 'doctor' when used in this title includes any medical practitioner licensed in the State in which the beneficiary received treatment."

[H. R. 9847, 75th Cong., 3d sess.]

A BILL Providing for the establishment of a national system of health insurance

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Insurance Act."

SEC. 2. In this Act, unless the context otherwise requires—

"Benefits" means the benefits for insured persons which are specified or approved under part III;

"Commission" means the Health Insurance Commission constituted under this Act;

"Contribution week" means any calendar week or part of a calendar week for which an employee who is an insured person within the scope of section 3 is entitled to receive remuneration from his employer; except that a calendar week in which an employee is entitled to receive remuneration from two or more employers shall be counted as one contribution week; and "contribution week" includes any other week designated by the Commission, pursuant to the provisions of subsection (5) of section 7, as a contribution week in respect of an employee;

"Dependent," with respect to any employee or other person, means every person who is wholly or mainly dependent for support upon the employee or other person; and who is resident in the United States, its Territories and possessions; and who is—

(a) the wife of the employee or other person; or

(b) the husband of the employee or other person; or

(c) the natural or adopted child of the employee or other person, and under the age of eighteen years; or

(d) the natural or adopted child of the employee or other person, between the ages of eighteen and twenty years, inclusive, if dependent upon them for support; or

(e) the natural or adopted child of the employee or other person, and over the age of eighteen years, and unable because of mental or physical incapacity to support himself; or

(f) any other member of the family or household of the employee or other person who is designated as a dependent by the Commission;

"Employee" means any person who is in receipt of or entitled to any remuneration for labor or services performed for another;

"Employer" includes every person directly or indirectly responsible for the payment or providing of the remuneration of an employee, and in respect of an employee in the service of the United States Government or in the service of a State government or in the service of a Territorial government includes the United States Government and the forty-eight States of the United States of America and the Territorial governments of the United States of America;

"Fund" means the health insurance fund established under this Act;

"Insured person" means any employee or other person within the scope of part I who is registered or is entitled to be registered as an insured person under this Act, and any dependent of an employee or other person so registered who is also registered or entitled to be registered under this Act. Insured persons who are employees and their dependents within the scope of section 3 shall be known as "employee insured persons". Insured persons who are persons and their dependents within the scope of section 4 shall be known as "voluntary insured persons";

"Medical services" includes all services and supplies designed for the prevention, cure, or alleviation of illness, injury, or physical or mental defect;

"Pharmacist" means any person registered as a pharmacist in any State or Territory of the United States of America or in the District of Columbia and duly licensed by the State board of pharmacy or other authorized board of any State, Territory, or the District of Columbia, to practice in that State, Territory, or District of Columbia.

"Physician" means any person registered as a physician in any State or Territory of the United States of America or in the District of Columbia and duly licensed by the State board of medicine or other authorized board of any State, Territory, or of the District of Columbia, to practice in that State, Territory, or in the District of Columbia;

"Prescribed" means prescribed by this Act or the regulations;

"Remuneration" means every form of compensation which an employee receives or is entitled to receive from an employer, and, without restricting the generality of the foregoing, includes wages, salaries, commissions, fees, bonuses, and the reasonable money value of board, rent, housing, lodging, or similar perquisites or emoluments;

"Resident in the United States", in respect of any person, means that the person has his main place of abode in the United States of America, including its Territories and possessions.

PART I—INSURED PERSONS

SEC. 3. (1) On and after a date to be fixed by the Commission and to be approved by the President of the United States, every employee who is resident in the United States of America and whose rate of remuneration is not greater than $1,800 per annum shall become and be an insured person and his dependents shall become and be insured persons under this Act.

(2) The provisions of subsection (1) shall not apply to—

(a) agricultural employees;

(b) any employee holding a certificate of exemption pursuant to subsection (3);

(c) any employee who is a member of an industrial medical-service plan the members of which are exempt pursuant to subsection (4).

(3) Where an employee otherwise within the scope of this section makes application for exemption in the manner prescribed by the regulations, and establishes to the satisfaction of the Commission that he is an adherent or member in good standing of any duly established church or cult and whereby such adherence or membership prejudices the employee by the teachings inculcated, the Commission shall grant to him a certificate of exemption from the provisions of this Act; but, subject to the regulations, such certificate may be canceled at the request of the employee or on the employee ceasing to be an adherent or member of any such church or cult.

(4) In case of any industrial medical-service plan which was in operation on the 1st day of January 1938, and which at that time was operated primarily for the benefit of the employees of a single employer, and embraced within its membership at least 75 per centum of the employees of that employer, and provided for its members at least the services of a physician for all cases of ordinary illness, or such other medical services as in the opinion of the governor and his council were equivalent to such services, the employees of that employer otherwise within the scope of this section who are members of that industrial medical-service plan shall be exempt from the provisions of subsection (1) if, at the date when this section became effective, they and their dependents, in the opinion of the President of the United States, under the continuation and development of their industrial medical-service plan, are reasonably assured of at least the services of a physician for all cases of ordinary illness and of hospital care thereof, or of such other medical services as in the opinion of the President of the United States are equivalent to those services; but if a majority of the employees of that employer otherwise within the scope of this section who are members of that industrial medical-service plan vote to come within the scope of this Act, by secret ballot, at a plebiscite of those employees taken at any time after the commencement of this Act pursuant to an order of the President of the United States therefor made on the request of bona fide representatives of those em-

ployees, or if it is established to the satisfaction of the President of the United States that those employees and their dependents are not in receipt of medical services equivalent to the services of a physician for all cases of ordinary illness and of hospital care therefor, the President of the United States may by order declare that those employees shall be subject to the provisions of subsection (1).

(5) Subject to the approval of the President of the United States, the Commission may from time to time and for any period of time exempt any or all of the following classes of employees from the provisions of subsection (1)—

(a) domestic servants employed in private households;

(b) casual employees; that is to say, those whose employment is irregular and for short periods of time;

(c) part-time employees;

(d) employees in designated establishments, industries, or localities, and other employees whom, in the opinion of the Commission, it would be unnecessary or inexpedient to hold within the scope of this Act.

(6) Subject to the approval of the President of the United States, the Commission may extend the provisions of subsection (1) to employees resident in the United States of America and its Territories and its possessions whose rate of remuneration is greater than $1,800 per annum, but less than $3,000 per annum, if such employees were, on the 1st day of January 1938, members in good standing of any industrial medical-service plan which ceases to provide medical services for its members after this section becomes effective.

SEC. 4. After a date to be fixed by the President of the United States, in the case of any person resident in the United States and in any of its Territories and possessions who is not an employee-insured person, if he makes application to the Commission to become a voluntary contributor under this Act, the Commission may admit that person to become and be an insured person and his dependents to become and be insured persons under this Act, subject to provisions of this Act and to such conditions as the regulations may prescribe.

SEC. 5. Every person who becomes an insured person under this Act shall be registered in the records of the Commission as an insured person in such manner as the regulations may prescribe and shall continue to be so registered and to be an insured person so long as he continues to be eligible to receive benefits in accordance with the provisions of section 17 or 18.

PART II—HEALTH INSURANCE FUND

SEC. 6. To meet the costs of all benefits provided and all salaries, outlays, and expenses incurred or payable under this Act there shall be constituted a fund, to be operated by the Commission and to be known as the "health insurance fund," in which shall be placed all moneys received from contributions made by insured persons and employers and all other moneys and income received by the Commission. The Commission shall deposit all moneys paid into the fund in one or more national or one or more State banks or in a separate fund with the United States Treasury to the credit of the Commission.

SEC. 7. (1) From the remuneration from time to time payable to each employee who is an insured person within the scope of section 3 his employer shall cause to be deducted an amount calculated at the rate of 2 per centum of the amount of the remuneration, except that—

(a) the amount to be deducted shall not be less than 35 cents per contribution week, unless a smaller amount is prescribed by the Commission with the approval of the President of the United States; and

(b) the amount to be deducted shall not exceed 70 cents per contribution week.

The employer shall, at such times and in such manner as the regulations may prescribe, pay over to the Commission the amount so deducted as a contribution from that employee to the fund.

(2) Every employer who is required to make a deduction from the remuneration of an employee pursuant to subsection (1) shall forward to the Commission with the contribution of his employee an amount calculated at the rate of 1 per centum of the amount of the remuneration payable to the employee as the employers' contribution to the fund in respect of that employee, except that—

(a) the amount of the employers' contribution shall not be less than 20 cents per contribution week in respect of the employee, unless a smaller amount is prescribed by the Commission with the approval of the President of the United States; and

(b) the amount of the employers' contribution shall not exceed 35 cents per contribution week in respect of the employee.

Where the United States Government is the employer the contribution shall be paid by the Secretary of the Treasury or whatever agency the Government may direct to make such payment for moneys appropriated for that purpose by Congress or, if no appropriation is available for that purpose, from whatever fund the President of the United States shall direct.

Where a State is the employer the contribution shall be paid by the treasurer from moneys appropriated for the purpose by the legislature or, if no appropriation is available for that purpose, from whatever fund the governor of each State shall direct.

Where a Territory or any possession is the employer the contribution shall be paid by the treasurer from moneys appropriated for the purpose by the legislature, or by the Secretary of the Treasury or whatever agency the Government may direct to make such payment from moneys appropriated for that purpose by Congress, or, if no appropriation is available for that purpose, from whatever fund the governor or head officer of each Territory and possession shall direct or, if said officer or officers do not possess proper authority, from whatever fund the President of the United States shall direct.

(3) Where the remuneration payable or provided by an employer to an insured person consists in part of board, lodging, housing, or other emoluments, perquisites, or privileges reducible to a money value, the employer shall notify the Commission of the particulars thereof, and the Commission may approve or fix an amount which shall be deemed to be the money value thereof for the purposes of this Act.

(4) Where an employee has more than one employer in any calendar week, the total amount of the employee's contribution and the total amount of employers' contribution shall not be greater than the amounts of the respective contributions that would have been deductible or payable if the employee had had only one employer in that week, and the regulations may prescribe that the total amount of the employers' contributions shall be payable by the first employer in that week or by any other of the employers in that week, or that part of the amount shall be payable by each of the several employers.

(5) Where an employee has no regular employer or has a number of employers, or where the remuneration which is payable to an employee fluctuates considerably from time to time because of seasonal or irregular employment, the Commission, subject to the approval of the President of the United States, may fix rates of contribution for the employee and his employers, and may prescribe the times and methods of deduction, payment, and remittance of moneys to the Commission other than and in substitution for the rates, times, and methods prescribed in subsections (1) and (2), except that the rates of contribution so fixed shall not in any case make the employee liable to a total contribution greater than $36 or his employer or employers liable to a total contribution greater than $18 in respect of any period of fifty-two consecutive weeks. The Commission may specify that the contribution of the employee shall be in respect of any number of weeks, whether the employee is entitled to receive remuneration for labor or services performed within these weeks or not, and the weeks so specified shall be deemed to be contribution weeks in respect of the employee.

(6) In case an employer who is liable to pay a sum of money to the fund as contributions in respect of an employee and himself fails to deduct the amount of the employee's contribution from the remuneration payable to him pursuant to the provisions of this section, the employer shall nevertheless be liable to pay the amount of the employee's contribution, as well as his own, to the fund.

SEC. 8. (1) Where an employer who is liable, under this Act, to pay a sum of money to the fund as contributions in respect of an employee and himself is—

(a) a contractor who performs work for any municipal corporation, or for any board or commission having the management of any work or service operated for a municipal corporation, the amount of the contribution may be paid by the corporation, board, or commission, as the case may be, and the amount paid may be deducted from any moneys due the contractor in respect of such work;

(b) a contractor who performs work for any person, both the contractor and the person for whom the work is undertaken shall be liable for the payment of the contributions, and the amount of the contributions may be levied upon and collected from either of them, or partly from one and partly from the other; but in the absence of any term in the contract to the contrary the contractor shall, as between himself and the person for whom the work is performed, be primarily liable for such contributions;

(c) a subcontractor who performs work for a contractor, both the subcontractor and the contractor shall be liable for the payment of the contributions, and the amount of the contributions may be levied upon and collected from either of them, or partly from one and partly from the other; but in the absence of any term in the subcontract to the contrary the subcontractor shall, as between himself and the contractor, be primarily liable for such contributions.

(2) The liability of any person for whom work is done in respect of any contributions to the fund required by this Act to be made by any contractor or subcontractor shall cease and determine within thirty-one days after the completion of the contract, unless the Commission within such time mails to the owner a notice of its claim by prepaid registered post addressed to the owner at his last-known address.

(3) The notice shall state the amount claimed and the name or names of the contractor or subcontractor primarily liable for such payment.

SEC. 9. No agreement to an employee to pay any portion of the contribution required to be paid by his employer under this part shall be valid, and no employer or other person shall make a deduction for that purpose from the wages of any employee, or in any other manner collect from an employee any portion of the contribution required to be paid by his employer.

SEC. 10. Every voluntary contributor who becomes an insured person under section 4 shall in accordance with the regulations make such contributions to the fund as the Commission, subject to the approval of the President of the United States, may determine; but the rates of contribution shall be so determined that the total of the contributions to be made by voluntary contributors shall be sufficient to cover the total costs of providing all benefits for voluntary insured persons and the administration expenses incidental thereto.

SEC. 11. The Commission shall, subject to the approval of the President of the United States, cause all moneys in the fund in excess of current requirements to be invested and reinvested in any securities which are legal for savings banks and which are considered a proper investment for trust funds. At least every three months, or at such times as the President of the United States may require, the Commission shall account to the President for all moneys so invested furnishing proper vouchers therefor. All investments shall be made in the names of the Commission and the Treasury of the United States jointly, if possible; if not, then in the name of the Commission and any other name the President shall direct, and all interest on investments shall be payable to the Commission and shall form part of the fund.

SEC. 12. Separate accounts shall be kept by the Commission of the moneys received and expended to provide benefits for employee-insured persons and voluntary-insured persons, respectively; but for the purpose of paying the costs of all benefits, outlays, and expenses under this Act the fund shall, nevertheless, be deemed one and indivisible.

SEC. 13. The accounts of the Commission shall be audited by the United States Treasury or by an auditor appointed by the President for that purpose, and the salary or remuneration of the last-mentioned auditor shall be paid by the Commission.

PART III—BENEFITS

SEC. 14. (1) Subject to the provisions of this Act and the regulations, the Commission shall provide benefits for insured persons as follows:

(a) The services of a physician when required for preventive, diagnostic, or therapeutic treatment and care, including prenatal and maternity treatment for women and surgical and specialist services, as may be necessary;

(b) Necessary hospital maintenance and care in a public ward, including drugs, medicine, and dressings, and all other services which the hospital is equipped to provide; but such hospital maintenance and care shall be provided for an insured person for not more than ten consecutive weeks for any one illness, unless a longer period is prescribed by the regulations: *Provided*, That, where an insured person choose to avail himself of semiprivate or private ward care or other hospital services more costly than those authorized under this clause and the regulations, the Commission shall apply toward the payment of the hospital bill of that insured person an amount equal to the cost of providing the benefits to which he would otherwise have been entitled under this clause;

(c) Necessary drugs, medicines, and dressings; subject to the provisions of the regulations, which may require that a part, not exceeding one-half, of the cost of such drugs, medicines, and dressings shall be borne by insured persons;

(d) Necessary laboratory services and diagnostic aids, including X-ray, biochemical, and other services.

(2) To the extent that the resources of the fund permit, the Commission may provide for insured persons such medical services, additional to those specified in subsection (1), as it considers to be valuable to protect and advance their health and well-being.

(3) Subject to the approval of the President of the United States, the Commission may make regulations to limit or to specify and define in greater detail the nature and extent of the various benefits authorized in subsections (1) and (2); to specify standards of service to insured persons to be observed by physicians, hospitals, laboratories, pharmacists, and other persons rendering such service; to prescribe that the provision of certain medical services shall be subject to small charges being borne by insured persons; and to designate the manner in which and the conditions upon which and the places at which benefits shall be granted.

Sec. 15. The benefits to be provided for insured persons shall not include any services for the diagnosis and treatment of tuberculosis, venereal diseases, nervous and mental diseases, or other diseases or conditions requiring medical treatment, when such services are otherwise available to insured persons free or at nominal charges through any public or governmental institution or organization.

Sec. 16. Where in respect of any sickness or injury an insured person—

(a) is in receipt of or is entitled to receive under any other Act of the legislature or of the Congress of the United States, or through any public or governmental institution or organization, treatment, care, or service similar to that which the Commission is authorized to provide by way of benefits under this Act; or

(b) is entitled to recover the cost of such similar treatment, care, or service by virtue of a claim against any other person for causing the sickness or injury.

no benefits shall be provided for that insured person under this Act in respect of that sickness or injury, except as the Commission may direct in case of urgent need.

Sec. 17. (1) Where an employee first becomes an insured person under this Act, he and his dependents (if any) shall not become eligible to receive benefits under this Act until after the expiration of four weeks from the time the employee became an insured person, nor until contribution to the fund from the employee for four contribution weeks have become deductible and payable; but after becoming eligible to receive benefits he and his dependents shall continue to be eligible during each succeeding contribution week in respect of the employee; and—

(a) for four additional calendar weeks; and

(b) for such further additional period as may be determined by the Commission, subject to the approval of the President of the United States.

(2) Where an employee who, having ceased to be eligible to receive benefits pursuant to the provisions of subsection (1), again becomes an insured person, he and his dependents shall not become eligible to receive benefits until after the expiration of one week from that time, nor until contributions to the fund from the employee for one contribution week have become deductible and payable; but after again becoming eligible to receive benefits in this manner he and his dependents shall continue to be eligible during each succeeding week in respect of the employee; and—

(a) for one additional calendar week; and

(b) for such further additional period as may be determined by the Commission, subject to the approval of the President of the United States.

(3) Where an employee who, having ceased to be eligible to receive benefits pursuant to the provisions of subsection (1) or subsection (2), is unable, because of sickness or injury, to engage in any employment, as may be determined by the Commission, he, but not his dependents, shall be eligible to receive benefits for a further additional period not to exceed twelve weeks, unless a longer period is prescribed by the regulations; and the regulations may prescribe that the employee's dependents shall be eligible to receive benefits for the same period as the employee.

Sec. 18. Voluntary insured persons shall become eligible to receive benefits under this Act and shall continue to be eligible in accordance with such conditions as the Commission, subject to the approval of the President of the United States, may determine.

SEC. 19. Without in any way limiting the power of the Commission under this Act to provide benefits for insured persons in such manner as it may consider expedient, the Commission shall, in all cases where it considers the circumstances do not require the exercise of such power in order to procure prompt, efficient, and economical medical service for the insured person, permit medical service to be administered, so far as the selection of physician or pharmacist is concerned, by the physician or pharmacist who may be selected or employed by the insured person, to the end that so far as possible all competent physicians and pharmacists without distinction may be employed and be available to insured persons.

SEC. 20. (1) Subject to the provisions of subsection (2), the Commission shall make all arrangements necessary to provide the benefits which insured persons are entitled to receive under this Act and shall arrange for the payment of the costs of such benefits. The fees or charges for benefits furnished and for traveling expenses incurred in providing such benefits under this Act shall not be more than would be properly and reasonably charged the insured person if he were paying them directly, and the amount thereof may be fixed and determined by the regulations, and no action for any amount larged than that fixed by the regulations shall lie in respect of such benefits.

(2) Any one of the following methods may be used for remunerating physicians who provide the services set out in clause (a) of subsection (1) of section 14:

(a) a salary system;

(b) a per capita system whereunder the physician is paid at the rate of a fixed amount per annum for every insured person eligible to receive benefits for whom the physician has accepted the responsibility of providing services;

(c) A fee system whereunder payment is based upon the exent and character of the services rendered; but where this system is adopted the total expenditures for any one year for the services of physicians shall not exceed a fixed rate per annum per insured person eligible to receive benefits, to be prescribed by the regulations, multiplied by the average number of insured persons eligible to receive benefits for that year, and for any portion of a year the total expenditures shall be limited pro rata. The rate shall be fixed to apply as from the date at which any insured persons first become eligible to receive benefits under this Act until the 31st day of March next succeeding, and the rate shall be revised semiannually thereafter to apply for the next succeeding period of six months, until the 31st day of March next succeeding; and thereafter the rate shall be revised annually to apply for the next succeeding year.

(d) Any combination or modification of the system designated in clauses (a) to (c):

Provided, That, if either of the methods of remuneration set out in clause (b) or clause (c) is used, or any combination or modification thereof, from the date at which section 3 becomes effective until the 31st day of March 1939, the Commission shall allocate, from the fund, moneys for the payment of physicians at the rate of not less than $4.50 per annum per insured person eligible to receive benefits.

SEC. 21. In addition to all other penalties prescribed by or under this Act, the Commission may penalize any person, including any physician or pharmacist, and the manager of any hospital or laboratory, who fails to provide services according to the standards prescribed by the Commission, and who willfully violates any provision of this Act or of the regulations, by debarring him, either permanently or for a limited period, from all rights of serving or of providing benefits for insured persons under this Act.

SEC. 22. The Commission may require from any person providing benefits to insured persons such reports or information as it considers necessary.

PART IV—ADMINISTRATION

SEC. 23. For the purpose of administering and carrying out the provisions of this Act, there is hereby constituted a Commission, which shall be known as the "Health Insurance Commission" and shall be a corporation. The Commission shall be composed of the Chairman and not more than four other members, to be appointed by the President of the United States as hereinafter provided. Two members shall constitute a quorum to transact business. No vacancy shall impair the rights of the remaining members to exercise all of the powers of the Commission so long as two members remain. In case of disagreement among the members in connection with any matter over which the Commission has authority, the vote of the majority, as shown in the Commission's record of proceedings, shall prevail and shall constitute the decision of the Commission.

SEC. 24. (1) The President of the United States shall appoint the Chairman of the Commission, who shall hold office for a term of seven years and shall be eligible for reappointment for succeeding terms of office of the same length. The Chairman may be removed from office by the President of the United States at any time for cause. The Chairman shall devote his full time to the service of the Commission and shall not hold any other position of trust or profit. He shall receive a salary of not less that $5,000 nor more that $7,500 per annum, as may be determined by the President of the United States. The Chairman shall be the chief executive officer of the Commission and, as its representative, shall supervise and direct the administration and enforcement of the Act.

(2) The President of the United States shall appoint not less than two and not more than four other persons as members of the Commission, each of whom shall hold office for a term of five years and shall be eligible for reappointment for succeeding terms of office of the same length. Any member may be removed from office by the President of the United States at any time for cause. Each member appointed under this subsection shall devote so much of his time as may be necessary to the service of the Commission, and, subject to the provisions of subsection (3), shall receive such remuneration from the fund as may be determined from time to time by the President of the United States, to an amount not to exceed $2,500 per annum.

(3) The President of the United States may at any time designate as Vice Chairman one of the members of the Commission appointed under the provisions of subsection (2), who shall hold office until the expiration of his tenure of office as a member of the Commission. The Vice Chairman shall assist the Chairman to supervise and direct the administration and enforcement of this Act, shall devote his full time to the service of the Commission, and shall receive in return therefor a salary not exceeding $3,500 per annum in addition to such remuneration as he may receive as a member of the Commission pursuant to the provisions of subsection (2).

(4) The Chairman shall appoint at any time, with the approval of the President, one person in each of the forty-eight States, Territories, and possessions, to be known as and to act as the health-insurance director, for a term of five years, and each shall be eligible for reappointment for succeeding terms of office of the same length. Any State director so appointed under this subsection shall devote his full time to the service of the Commission's business in the State, and shall receive in return therefor remuneration from the fund to an amount not to exceed $2,500, as a salary, per annum, and the Territories and possessions are included as States for the purposes of this subsection.

SEC. 25. (1) The President of the United States may appoint, for the term of five years, not more than six persons to constitute a technical advisory council. The members to be appointed shall be persons equipped by special training or experience to assist and advise the Commission, and shall include the commissioner of the department of health, or the Surgeon General; and the chairman of the Social Security department; the chairman or some other representative of the Department of Labor which deals with industrials, accidents, and other labor problems in connection with the general health of laborers and others; and a physician with experience in private practice. At least one member of the technical advisory council shall be a woman. Members shall be eligible for reappointment for like terms of five years. The members of the technical advisory council shall meet at the call of the Commission. It shall be the duty of the technical advisory council to assist and advise the Commission with respect to the establishment and administration of a system of health insurance.

(2) The members of the technical advisory council shall be paid out of the fund the amount of the traveling and other expenses necessarily incurred by them in the discharge of their official duties; but they shall not receive any remuneration for their services, except as may be determined by the Commission with the approval of the President.

(3) The President of the United States may appoint, for the term of five years, not more than six persons to constitute a technical advisory council, in each State, Territory, and possession of the United States, so that each State, Territory, and possession will have a separate technical advisory council to meet with and advise the State health insurance director of that said State, Territory, or possession. The members to be appointed shall be persons equipped by

special training or experience to assist and advise the Commission and each State director, including the Territories and possessions, and shall include the Commissioner of Public Health or some other member of said department, the chairman or some other representative of the industrial accident department, and a physician with experience in private practice. At least one member of each technical advisory council shall be a woman. Members shall be eligible for reappointment for like terms of five years. The members of each or all of the technical advisory councils shall meet at the call of the State director or at the call of the Commission. It shall be the duty of each technical advisory council to assist and advise the State director and the Commission with respect to the establishment and administration of a system of health insurance.

(4) The members of the technical advisory councils of the States, Territories, and possessions shall be paid out of the fund the amount of the traveling and other personal expenses necessarily incurred by them in the discharge of their official duties; but they shall not receive any remuneration for their services, except as may be determined by the Commission with the approval of the President of the United States.

SEC. 26. (1) The Commission, subject to the approval of the President of the United States, shall appoint and employ a physician as director of medical services, shall fix his salary, and shall determine his duties.

(2) The Commission shall appoint and employ such other physicians, officers, employees, and assistants as may be required for the administration and enforcement of this Act; shall determine their duties; and, subject to the approval of the President of the United States, shall fix their remuneration. All officers or employees receiving or disbursing moneys of the Commission shall give bonds in amounts and with sureties to be approved by the Commission.

SEC. 27. The Commission shall administer this Act and shall have, in addition to the duties imposed and powers granted elsewhere in this Act, the following duties and powers:

(a) Subject to the approval of the President of the United States, to make all such regulations, not inconsistent with the provisions of this Act, as it may consider necessary to implement, to administer, and to enforce this Act;

(b) To require that unless claims for compensation in connection with medical services rendered to insured persons by physicians, pharmacists, hospitals, or other persons are filed with the Commission within a reasonable period of time after the performance of such services, as may be determined by the Commission, the Commission shall not be liable to meet such claims for compensation;

(c) To make such expenditures from the fund as may be necessary to provide for the proper administration of this Act and to provide benefits for the insured persons entitled thereto;

(d) To appoint local committees to advise on and assist in the administration of this Act in local districts;

(e) Subject to the approval of the President of the United States, to enter into agreements with the Government of the United States or any body established by that Government to act in its behalf and with the government of any State, Territory, or possession or any body established by any State, Territory, or possession to act in its behalf to accept financial subventions to assist in meeting the costs of the benefits for insured persons authorized under this Act;

(f) Subject to the approval of the President of the United States, to enter into an agreement with the Government of the United States, and with the government of each State, Territory, and possession of the United States to provide for the bringing within the scope of this Act the employees of the United States Government and the employees of each State, Territory, and possession of the United States;

(g) To investigate the problem of providing cash payments for employees unable to work on account of sickness, and to report its findings thereon to the President of the United States;

(h) To organize and administer voluntary hospital insurance plans in cooperation with any hospitals that desire to participate;

(i) Generally to do all other things necessary to carry out the full intent of this Act.

SEC. 28. (1) All regulations made by the Commission under the authority of this Act shall be published in the public press, and each regulation shall have effect from the date of publication, or from a later date specified in the regulations, as if enacted in this Act; and all regulations shall be laid before the Congress of the United States as soon as may be after they are made.

(2) The President of the United States may by order at any time rescind the approval given to any regulation made by the Commission under the authority of this Act and may cause a notice of the order to be published in the newspaper; and thereupon the regulation in respect of which approval is rescinded shall cease to be in operation.

Sec. 29. (1) The Commission shall, on or before the 1st day of March in each year, make a report to the President of the United States of its transactions during the last preceding calendar year, which report shall contain such particulars as the President may prescribe.

(2) The report shall be forthwith laid before the Congress of the United States if it is then in session, or, if it is not then in session within fifteen days after the opening of the next session.

Sec. 30. (1) The Commission shall have the like powers as the United States Federal courts for compelling the attendance of witnesses and of examining them under oath, and for compelling the production and inspection of books, papers, documents, and things in connection with any inquiry, hearing, or proceeding of the Commission under this Act.

(2) The Commission may cause depositions of witnesses residing within or without the United States to be taken before any person appointed by the Commission in a similar maner to that prescribed by the rules of the Federal courts for the taking of like depositions in any of said Federal courts before a commissioner.

Sec. 31. Any inquiry which the Commission considers necessary may be made by one of its members or by an officer of the Commission, or by some other person appointed by the Commission to make the inquiry; and the Commission may act upon his report as to the result of the inquiry, and every such member, officer, or person appointed to make an inquiry shall, for the purposes of the inquiry, have all the powers conferred upon the Commission by section 30.

Sec. 32. No officer or employee of the Commission and no person authorized to make an inquiry under this part shall divulge or allow to be divulged, except in the performance of his duties or under authority of the Commission, any information obtained by him or which has come to his knowledge in making or in connection with an inquiry under this Act.

Sec. 33. Every employer within the scope of this Act shall keep a true and accurate record of the full name and residential address of each of his employees, the remuneration paid or payable to such employee, and the days of employment for which such remuneration is payable to the employee, and shall upon demand furnish the Commission with a statement of the record verified under oath, and shall upon demand permit the inspection of the record by the Commission or any of its officers at any time and as often as may be necessary to verify the names or numbers of employees, the amounts of remuneration paid or payable, and their days of employment.

Sec. 34. Every employer, including employers not otherwise subject to the provision of this Act shall furnish to the Commission upon request all information in his possession required by it to carry out the purposes and provisions of this Act. The Commission may prescribe the time, manner, and form in which the information shall be furnished and may require that the information be verified under oath. The information shall be for the exclusive use of the Commission and shall not be available to the public, except that it may be tabulated and published in statistical form if the business affairs of individual employers are not thereby revealed.

Sec. 35. (1) The Commission shall have exclusive jurisdiction to inquire into, hear, and determine all matters and questions of fact and law arising under this Act, and no proceedings by or before the Commission shall be restrained by injunction, prohibition, or other process or proceeding in any court, or be removable by certiorari or otherwise into any court.

(2) Notwithstanding the provisions of subsection (1), the Commission shall have full discretionary power at any time to reopen, rehear, and determine any matter which has been dealt with by it.

Sec. 36. (1) Every insured person who applies for or is in receipt of any benefits under this Act, if requested by the Commission, shall submit himself to medical examination at such time and place as it may direct. If the insured person fails to submit himself to such examination, or obstructs the same, his right to benefits may be suspended until the examination has taken place.

(2) If in the judgment of the Commission, an insured person persists in such practices as tend to imperil or retard his recovery or refuses to submit to such medical treatment as is necessary to promote his recovery, the Commission may,

in its discretion, reduce or suspend the benefits to which the insured person would otherwise be entitled.

SEC. 37. No agreement, by an insured person entitled to any of the benefits provided by this Act, to waive any right or any of the benefits under this Act shall be valid.

SEC. 38. If any benefits are paid for or furnished by the Commission under this Act in the event of sickness or injury to any person who by reason of the sickness or injury has a right or claim for compensation or medical services against an employer or any other person for causing the sickness or injury and for the damages resulting therefrom, or has a right or claim for compensation or medical services under the Workmen's Compensation Act or any other Act, the fund shall, to the extent of the benefits so paid for and the cost of the benefits so furnished, be entitled to reimbursement out of any sum or damages or allowance which that person receives by way of compensation or payment for medical services or through suit or judgment in settlement of his right or claim, and the Commission shall, to that extent, be subrogated to the said right or claim as against such employer or other person.

SEC. 39. (1) If any person otherwise entitled to receive benefits provided by this Act for sickness or injury has such right or claim as described in section 38 and refuses or neglects to take the necessary action to enforce his right or claim within such time as may be fixed by the Commission, it shall be lawful for the Commission to take action or institute proceedings at its own expense in the name and in behalf of the said person.

(2) In case any judgment or award is granted in behalf of an insured person in consequence of an action or proceding under subsection (1), the Commission shall be entitled to recover its reasonable costs and expenses in connection with such action or proceeding from said judgment or award in addition to its claim for reimbursement against the insured person. But the liability of the insured person to reimburse the Commission shall be limited to the amount of money collected in respect of said judgment or award.

SEC. 40. (1) The payment of every sum of money which any employer or person, other than the United States Government and the government of any State, Territory, and possession, is required by this Act or the regulations or by any agreement entered into under this Act to pay or forward to the Commission may be enforced by action in any court of competent jurisdiction in the name of the Commission, together with the costs of the action, as for a debt due by that employer or person to the Commission.

(2) Where default is made by any employer or person in the payment or forwarding to the Commission of any sum of money referred to in subsection (1) or any part of that sum, the Commission may issue its certificate stating that the sum so required to be paid or forwarded, the amount thereof in default, and the name of the employer or person by whom it was required to be paid or forwarded; and such certificate, or a copy of it certified by any member of the Commission to be a true copy, may be filed with the registrar or clerk of any court either Federal or State, and when so filed shall become an order of that court and may be enforced as a judgment of the court against that employer or person for the amount stated in the certificate.

(3) In the case of every amount payable to the Commission under this Act by an employer other than United States Government and government of any State, Territory, and possession, the Commission shall as between itself and any other person be entitled to the same rights of priority in respect of the payment of that amount as the United States Government and the governmentof any State, Territory, and possession would have if that amount were a debt due from that employer to either the said national or the said governments of any State, Territory, and possession.

SEC. 41. (1) If any sum of money which any employer or person, other than the United States Government and the governments of any State, Territory, and possession, is required by this Act or the regulations or by any agreement entered into under this Act to pay or forward to the Commission, or any part of it, is not paid or forwarded at the time when it was so required to be paid or forwarded, the defaulting employer or person shall be liable to pay and shall pay to the Commission as a penalty for his default such a percentage upon the sum in default as may be prescribed by the Commission, and the penalty shall be added to the sum so in default and shall for all purposes of this Act be deemed to become and be a part thereof.

(2) Every person who in violation of any provision of this Act does any act which is prohibited from doing or refuses or neglects to perform or observe

any duty or obligation imposed on him shall be guilty of an offense against this Act and shall be liable, on summary conviction, to a fine of not less than $10 and not more than $500.

(3) The Commission may by the regulations provide fines, recoverable on summary conviction, for the enforcement of the provisions of the regulations, but in no case shall the fine exceed the sum of $50.

(4) All fines imposed under subsection (2) or (3) shall, when collected, be paid over to the Commission and shall form part of the fund.

SEC. 42. Every notice or request which the Commission or any member, or officer, or representative of the Commission is empowered or required to give or make under the provisions of this Act or the regulations shall be in writing, and may be served either personally or by mailing it by letter to the address of the person to whom it is given or made. Where a notice or request is mailed, service of the notice or request shall be deemed to be effected at the time at which the letter containing it would be delivered in the ordinary course of post.

PART V—COMMENCEMENT OF ACT

SEC. 43. This Act shall come into operation on a day to be fixed by the President of the United States by a suitable proclamation.

(Whereupon, at 5:15 p. m., the subcommittee adjourned until 10 a. m. Thursday, January 29, 1948.)

NATIONAL HEALTH PROGRAM

THURSDAY, JANUARY 29, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee room, Capitol Building, Senator H. Alexander Smith (chairman of the subcommittee) presiding.

Present: Senators Smith (presiding), Donnell, and Murray.

Senator Smith. The committee will come to order. Mr. Cohen, will you take the stand and give us the statement that you propose to make this morning?

STATEMENT OF WILBUR J. COHEN, ASSISTANT DIRECTOR, BUREAU OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION—Resumed

Mr. Cohen. Mr. Chairman and gentlemen, the purpose of my statement this morning is to present to you in somewhat more detail the actual background of the events that led up to teleconversations which Senator Donnell referred to in the previous hearing. I do so in order to indicate to you what is my personal opinion, and from my own personal knowledge, that this mission was not taken on our initiative and was taken on the initiative of responsible officials of the War Department, and that as a matter of fact, as I will attempt to show you, curiously enough we were exceedingly reluctant to become members of the mission, and it was only at the continued and insistent request of the officials of the War Department that we finally complied with what we thought was a great need on the part of our military officials in Japan for our technical help.

The first that we had any knowledge of the developments relating to Japan occurred approximately in the spring of 1946, when Mr. Oscar Weigert and Mr. Tillman Sogge, who were members of what is called a Labor Advisory Mission of SCAP, submitted a report entitled "Report on the Japanese Social Insurance Program by the Labor Advisory Mission, Tokyo, Japan, May 1946." This is a 23-page report with some additional pages as introduction, summary, and table of contents. That was the first time I had heard anything about the study of the Japanese social-insurance program, when these two gentlemen came in to see Mr. Altmeyer, the Commissioner for Social Security, and myself, on their return from Japan.

During the course of the discussion by Mr. Weigert and Mr. Sogge with us about the situation in Japan, they asked us to suggest candidates for positions in the Public Health and Welfare Section, General Headquarters, Supreme Command for the Allied Powers in Tokyo. Mr. Weigert and Mr. Sogge sent to Mr. Altmeyer a copy of this report that I have mentioned.

Also, in the spring of 1946 Mr. Paul Stanchfield conferred with Mr. Altmeyer and myself regarding technical assistance in the social-security work of SCAP in Tokyo. May I say in passing that as far as I know we had absolutely no connection whatsoever with the selection of Mr. Stanchfield for the position in Tokyo, although he was a Government employee here in Washington. It has been implied that there was some connection with us. The first that I knew anything about Mr. Stanchfield's responsibility in connection with the Japanese work was when he came in and said he was going to Japan, and asked whether we had any material or any help or any suggestions for people who ought to go out there.

Later, August 2, 1946, I received a letter from Mr. Sogge, who was then a staff member of the Bureau of the Budget, listing four positions in the field of social security in Japan for which the War Department had asked him to assist in soliciting candidates. Mr. Sogge requested that publicity be given these positions among State agencies, social security and regional offices, because of the difficulty they were finding in recruiting people for that work at such a long distance, and because of the separation from their families. We were not able at that time, I believe, to suggest anyone, and if my memory serves me correctly, at that time we did not, and we were not able to find anyone who was willing to be nominated for serious consideration for any of these Japanese positions.

Later on in 1946 Mr. Stanchfield returned to the United States with authority from SCAP to recruit personnel.

Senator Donnell. Do you know the date of Mr. Stanchfield's arrival in the United States?

Mr. Cohen. I could not say. I have tried to check that up, Senator. I have it late in '46. My impression from other documents is that it was in December 1946, but I do not know the exact date. As I say, he came here to recruit personnel for Colonel Sams, Chief of the Public Health and Welfare Section of SCAP.

Now, this will come up later and I would like to take a moment at this time to say that Colonel Sams is the responsible War Department official, General MacArthur's staff, in charge of all the public-health and welfare work in Tokyo, including social security, and we believed, and still do believe, that as the responsible official for General MacArthur he was acting with full authority, and that Mr. Stanchfield coming here to recruit personnel for him was acting with full authority and full knowledge of his superior. Colonel Sams later on will appear in these teleconversations, and I make that point because I believe it is fair to assume that, with Colonel Sams in attendance as the responsible representative of General MacArthur, we certainly were on sound ground in believing that all of our discussions and negotiations with the War Department through Mr. Stanchfield and Major Simmons; and indirectly by teleconversation with Colonel Sams, were with the full knowledge and approval of either General MacArthur or through Colonel Sams at the delegation of General MacArthur.

When Mr. Stanchfield had difficulty recruiting people to go to Japan to take jobs in the Public Health and Welfare Division, it was Mr. Stanchfield himself who personally suggested to me in one of our numerous conversations that perhaps the solution of the problem of recruiting personnel for a year or two would be the formation of a temporary ad hoc commission to go to Japan headed up by Mr. Altmeyer, to provide the necessary technical assistance to them.

I discussed this suggestion of Mr. Stanchfield's with Mr. Altmeyer, whose reaction was that, of course, he wanted to do everything possible to help General MacArthur in his duties over there: however, he was exceedingly reluctant to do it at that time because he said he had no personal information as to whether this was important to General MacArthur or not, and as the Commissioner for Social Security, with his heavy responsibilities here, he did not feel that he should leave here for 6 weeks or 2 months, as the case might be, unless General MacArthur himself felt it was something in which Mr. Altmeyer personally could make a contribution, that it was important to General MacArthur in his work, and that it would be a real contribution. I stressed that point to Mr. Stanchfield several times, and Mr. Stanchfield discussed it personally with Mr. Altmeyer. Thereafter Mr. Stanchfield communicated with Tokyo, and it was my understanding he obtained instructions from them to proceed with the plan for a social-security mission which he and Major Simmons, of the Civil Affairs Division of the War Department, which handled these matters, had discussed with Mr. Altmeyer before Mr. Stanchfield returned to Tokyo.

Major Simmons and Mr. Stanchfield urged that this matter be put into some written document, showing that we were willing to offer cooperation with General MacArthur. As I said, that was quite embarrassing to us, because of the fact that no member of our staff appeared to be willing to go, and that we were the responsible Federal agency to give help on this, made us feel that their continued requests that we show a willingness to provide technical assistance was such that on March 5, 1947, Mr. Altmeyer wrote a letter to Major Simmons in which he recorded his reactions to the arrangements for the mission proposed by the War Department to Mr. Stanchfield.

I don't know whether you have that letter in the record or not, but if you would like it, it could be put in the record.

Now, the importance of that is this. After that letter was sent, on March 14 a teleconversation was held with Tokyo by Major Simmons. I don't know whether Senator Donnell put that in the record yesterday or not, but the importance of that, to my mind, is that was a teleconversation with Tokyo by Major Simmons, and at the other end with Colonel Sams, as I said, the responsible official of General MacArthur's staff, and we were not in attendance. No member of the Social Security Administration staff was at that time in attendance at that teleconference.

Mr. Altmeyer's letter of March 5 was teletyped to Tokyo.

Senator DONNELL. Mr. Cohen, if you have not objection, permit me to refer to a letter from Mr. Altmeyer to Major Simmons on March 5, 1947.

(The letter referred to appears on p. 2039.)

Mr. Cohen. Mr. Altmeyer's letter, which the Senator has just referred to, was teleconned to Tokyo and the reply that was received back from Tokyo at that time is as follows—keeping in mind that no official of the Social Security Board was in attendance during this two-way conversation.

FEC item 1.

Reur WD–1, concur in proposal of Mr. Altmeyer. Mr. Wandel can be employed by OSW for 6 months period on reimbursable basis and designated as chief of Social Security Division PH&W while in Japan, according to office Civilian Personnel here. Firm request will be forwarded with air priority for Mr. Wandel by radio for him to arrive in Japan May 1. Radio will also be forwarded within next few days extending formal invitation for social-security mission. Desire arrangements be made for successor to Wandel to arrive Japan by September 1 to insure 1 month overlap if possible. Neff is chief of Welfare Division, Evans is chief of welfare institutions, Markusson is public-assistance chief, and Ernest Witte is scheduled to arrive as social-work training consultant. If Altmeyer desires additional member for welfare on mission, it is agreeable to PH&W. Suggest Mr. Falk be included on mission if possible.

Major Simmons then replied as follows:

WD–12. Reur item 1.

This is good news. Will advise Altmeyer immediately and work out further details with you by radio.

There then follows a series of teleconversations which have nothing to do with this Social-Security mission, on other matters relating to Tokyo, and finally there is contained an item from Tokyo, as follows:

Senator Donnell. What is the date of this?

M. Cohen. This is all in the same teleconversation. It is just that I didn't think you wanted to be burdened with irrelevant material.

Senator Smith. I am assuming, Mr. Cohen, that you are arranging in proper order these teleconversations for the record as you want to present your side of the case.

Mr. Cohen. Yes, sir; and I am only reading to you now excerpts from them because the entire matter will be in the record.

Senator Smith. I want to leave that to your judgment.

Mr. Cohen. There is a lot in here about bacteriologists and parasitologists and other matters connected with health, but nothing related to the Social-Security mission.

Tokyo then wired this statement on their own initiative:

FEC item 10.

Suggest George Perrott United States Public Health Service be included in mission as study is now under way here on drafting national-health bill for Japan

Senator Donnell. What is the date of this, so that we may have the record clear?

Mr. Cohen. March 14, sir.

Senator Donnell. March 14, 1947?

Mr. Cohen. Yes, Senator, that is correct.

Senator Donnell. All right.

Mr. Cohen. And for identification, this is known as FEC item 10.

Suggest George Perrott, United States Public Health Service, be included in mission as study is now under way here on drafting national health bill for Japan. By Japanese Council especially established for the purpose by ministry of health and welfare. National and prefecture hospital systems to be integrated with health-insurance program and public health center system.

That communication came from them, as I say, on their own initiative, with none of our people in attendance either here or in Japan.

Senator SMITH. Who was it sent you that message?

Mr. COHEN. Tokyo.

Senator SMITH. Who in Tokyo.

Mr. COHEN. I will tell you who the people were. It says present were Col. W. D. Tigert. I believe he had nothing to do with this. He was probably on other conversations on the bacteriologists and parasitologists. Col. C. F. Sams, Chief P. H. and W., Mr. P. I. Stanchfield, Mr. George F. Pollock, Deputy Chief, Social Security and Insurance Division, Miss Leone M. Moor, Personnel Coordinator, P. H. and W., Miss R. Sullivan, Civilian Personnel Section, subject: "Personnel for social security and insurance division PH and WS and 406th Medical General Laboratory," which must be the reference to the other points. So this communication came to us and Major Simmons then replied:

> WD-16. Reur item 10.
>
> Will try to secure Perratt.

Then Tokyo replied:

> FEC item 11.
>
> Suggest possible inclusion in the Altmeyer mission of Dr. Oscar Weigert and/or Dr. Tillman Sogge, formerly in Tokyo as members of labor advisory committee, if they can be available. Weigert can be contacted through CAD at Bureau of Labor Statistics, Labor Department, Washington. Sogge is at St. Olaf's College, Minnesota, and has indicated he might be available during summer vacation.

Major Simons then replied in WD-17:

> Reur item 11. Dr. Sogge and Dr. Weigert are excellent suggestions and feel sure they will come if at all possible. Include them and Perratt in cable requesting invitation to Altmeyer.

Now that concludes the relevant material in the March 14 teleconversation which was the basis for latter receipt by the Social Security Administration of an official communication to proceed with the plans for this work.

In other words, they gave approval to Mr. Altmeyer's communication of March 5 and shortly thereafter Major Simmons came over and talked with me and informed me that he had received this telecon clearance with Japan on the proposed social-security missions outlined in Mr. Altmeyer's letter.

Mr. Altmeyer was out of the country at that time and consequently Major Simons handled the matter with me per Mr. Altmeyer's delegation of the matter to me in his letter of March 5.

He told us that a letter from the Secretary of War would be sent to us very shortly requesting that Mr. Wandel arrive in Japan about May 15. I then proceeded to have further conversations with both Mr. Perrott and Mr. Falk, and Mr. Weigert, and I think with Mr. Sogge by mail, but I don't remember.

I talked with Mr. Perrott and Mr. Perrott did not wish to interrupt his work at that time to go to Japan. I consulted with other persons about the desirability of going on the mission, but it was agreed after much discussion that it would be better for Mr. Wandel to go over per the request of the War Department, and on the spot find out specifically what the needs were there and then let us know what type of personnel was required.

In other words, we didn't feel that we were in a position here, thousands of miles away from Japan, to determine what particular specialties or professional skills were required to assist them, but that if Mr. Wandel, an intelligent and capable member of the staff was on the spot he could find out what their needs were and let us know.

I make that point because in my mind that largely explains the type of letter which Mr. Wandel later on wrote to Mr. Falk, which Senator Donnell referred to earlier in these hearings, in which he told somewhat more about the problems that they had in Japan, the organization of the division and the need for particular personnel at particular grades. Mr. Wandel did go to Japan.

Senator SMITH. That was in May?

Mr. COHEN. Mr. Wandel left—he was transferred to the War Department pay roll May 1, 1947.

Senator SMITH. Did he leave about that time?

Mr. COHEN. Approximately. He had to go through certain processing and so on, but if my memory serves me correctly, I believe it was sometime in May, and no further steps were taken at that time.

Now with regard to the teleconversation of July 17 that Senator Donnell introduced in the record the other day, my work in the Social Security Administration is largely connected with legislative hearings and other legislative work, applying to requests of Members of Congress, and I usually take my vacation shortly after the Senators and the Congressmen leave. I was planning to go on an extended vacation.

Senator SMITH. You believe in early adjournments then, do you?

Mr. COHEN. I certainly do, Senator. [Laughter.]

I find that at the end of a long session I am usually as tired as the Senators.

Senator SMITH. I agree with you.

Mr. COHEN. Consequently I indicated to Major Simmons in our discussions that before I left on my vacation (I was going to Texas) that it might be best since Mr. Altmeyer was gone, for us to have a conversation with Mr. Wandel to see if there was anything more that was needed. I didn't want to be gone for 4 or 5 weeks and leave the matter hanging since it was my responsibility, because I felt that since Mr. Wandel had gone over there at the request of the War Department, I should see that anything that they wanted from us was handled expeditiously.

It was therefore arranged to have this teleconversation of July 17 about a week or so before I left on my vacation. That was the reason for the teleconversation, and since I was leaving for 5 weeks I asked Miss Mulliner, the executive assistant, to come with me so that if there were any matters that needed handling during my absence she could take care of them.

That accounts for the presence of these two representatives of the Social Security Administration, and of course Major Simmons of the Civil Affairs Division was there and he was responsible for approving, editing, and changing these communications that we sent to Tokyo.

At the other end of the line in Tokyo was Col. Crawford F. Sams, the chief of the Division, Mr. William Wandel, Mr. George Pollock, and Mr. George Rohrlich, and Mrs. Leone M. Moor.

The first communication, re WD–1, that was referred to, I think is very important in that we wrote with the approval of Major Simmons this sentence, and I am going to now be reading some things just excerpts because I don't want to read the whole thing, just the relevant material:

> * * * Now that you have had the opportunity to review the situation to learn your desires concerning the composition of the mission before Mr. Cohen leaves.

In other words, Senator, this was an attempt to find out what the people in Tokyo wanted. We were trying to be helpful. We were not trying to designate the members of the mission or who it should be or what they should do.

I honestly wanted, as this communication indicates, to find out who they wanted and what they wanted done. I continued on that same line in these teleconversations in which I finally wrote this, which I think gives an idea of the fact that we wanted them to set the standards for the mission, the personnel, and its character.

Senator DONNELL. Pardon me, Mr. Cohen. For the record I think if it doesn't appear already, WD–1 was stated to be for Wandel?

Mr. COHEN. Yes.

Senator SMITH. He had been there then about 2 months, hadn't he?

Mr. COHEN. That is correct, sir. He had been there about 2 months. I couldn't tell you, Senator, why it says for Wandel——

Senator DONNELL. If I am wrong, please correct me. As I understand it, each one of these serial numbers designates a particular individual for whose attention that was intended.

Mr. COHEN. Yes.

Senator DONNELL. WD–1 is described for Wandel just as WD–2 is described for Rohrlich?

Mr. COHEN. That's correct; although I am advised that Colonel Sams, who was the senior official there, approved and was responsible for seeing that the messages from Tokyo that were sent here were transcribed and sent just as my messages to Tokyo were edited and changed and approved by Major Simmons before he sent them.

As a matter of fact, he made several changes that we discussed and debated for a few minutes before they were sent.

Senator DONNELL. However, WD–1 reads, does it not, as follows:

> WD–1. for Wandel:
>
> Mr. Altmeyer has not yet returned from Europe and departure of social-security mission may be delayed. Mr. Cohen is leaving town in a few days for an extended period, so it is deemed essential, now that you have had the opportunity to review the situation, to learn your desires concerning the composition of the mission before Mr. Cohen leaves.

Mr. COHEN. That is correct, sir.

Now in message WD–5, which doesn't have any indication at all on it, Senator, whom it is for, which I would now like to read:

> We would like to obtain further information from SCAP in order to begin our planning for the social-security mission.

Senator DONNELL. Pardon me, Mr. Cohen. For the record, that is the first one of the first five that does not contain the designation as to whom it is for, for whom the particular paragraph is intended. That is correct, isn't it?

Mr. COHEN. I think that is correct, Senator.

Senator DONNELL. So the record may be clear, WD–1 is marked for Wandel, WD–2 for Rohrlich, WD–3 for Janis, WD–4 for Wandel, and WD–5 not stating for whom it is.

Mr. Cohen. That is correct, sir.

Senator Donnell. Mr. Wandel has been designated by Mr. Altmeyer to go to Japan. That is correct, isn't it? Who selected Mr. Wandel to go?

Mr. Cohen. The first discussions concerning Mr. Wandel were directly between Mr. Stanchfield and Mr. Wandel. Mr. Stanchfield then informed me that Mr. Wandel was willing to go. Then after that was so, Mr. Altmeyer suggested his name in the letter of March 5.

Senator Donnell. Yes; that is the letter that was offered in evidence this morning.

Mr. Cohen. Yes, sir.

Senator Donnell. That's right, and Mr. Altmeyer said, and I quote:

> I would want Mr. William H. Wandel, Chief of the Program Division, Bureau of Employment Security, to serve on the mission; in order to do the necessary preparatory work he should precede us to Japan by about 3 months and should remain for 3 months after our visit in order to finish up the necessary details.

That is correct, isn't it?

Mr. Cohen. That is correct, sir.

Senator Donnell. All right, proceed.

Mr. Cohen (reading):

WD–5.

> We would like to obtain further information from SCAP in order to begin our planning for the social-security mission. Altmeyer will probably not return from Europe before the end of August or early September and pending business here makes it impossible to say now what his schedule will be. In order that he may make his plans when he returns, we should like to have a recommendation from you as to when the best time or times would be for the mission to arrive, what emphasis should be given in selecting personnel for the mission, how many persons should be in the mission, what specifically the mission would do, how long it would stay, and what materials could be sent to members of the mission before it departs. Could you give us now some indication of your suggestions on these matters and follow them up with a detailed memorandum specifically outlining your recommendations on these and any related points. Do you have any suggestions you want us to consider?

Senator Smith. By whom is this signed?

Mr. Cohen. This next one comes from Tokyo.

Senator Smith. Any special names?

Mr. Cohen. No, sir; they were not signed as specific names.

Senator Smith. This was in reply to what you have just read?

Mr. Cohen. Yes, sir; this is in reply to what I sent to Tokyo. This is FEC item 4, reference item 5.

> Urgent that mission arrive not later than September 1, even if Mr. Altmeyer cannot accompany mission at that time. Desire mission for 60 days and purpose of mission to be to consult with Public Health and Welfare and with Japanese Committee on Social Insurance and Japanese Council on Medical Care for purpose of drafting a national health bill which will incorporate a unified national health insurance program with a national medical care program. This bill must be available to present to Diet not later than October 1. Do deem it important to get Dr. Perrott and others familiar in this field together with Mr. Cohen. Japanese groups continuing studies. Report by Social Security Division should be completed shortly after August 1 and can be sent to Cohen.

Senator Donnell. Mr. Cohen, did you learn at any time who is the author of FEC item 4, which you just read?

Mr. Cohen. No, sir; I did not. I did learn this, that the writing of these communications in Tokyo was somewhat similar to our writing them here, that is, one of the persons would make a draft, circulate it around to the other persons who were sitting around the table, each person would make such amendments and additions and changes, and finally it was transmitted—at least I can speak with authority here at the Washington end—to the War Department official, Major Simmons, for final editing and approval, and he then handed it to the person who transmits it.

In other words, the civilian person—at least I was not able or authorized to transmit directly to the person sending these teleconversations what I would have preferred to send myself. They were all sent through Major Simmons, but I can't answer your question specifically, Senator, from my own knowledge.

The reason I have read that is because it does indicate that the initiative came from the people in Tokyo, the urgency of the mission and their own needs, and the fact that they urged us again very strongly to come, and to come quickly.

Senator DONNELL. Well, that was in response, however, to WD–5, which said:

> We should like to have a recommendation from you as to when the best time or times would be for the mission to arrive.

Mr. COHEN. Yes, sir.

Senator DONNELL. That you read a while ago, so that the question as to when the arrival should take place originated not in FEC item 4 but in WD–5, and was an inquiry from this end of the line, was it not?

Mr. COHEN. That is correct, Senator, because we had no knowledge of how urgent it was or when they wanted us to arrive, and I must say I was quite surprised at the time when we received this that they wanted us to organize the mission so quickly and to come so speedily. Then I should like to read WD–8, Senator.

Senator DONNELL. Do you mind reading 6 and 7 also, so we may have them consecutively? I have them here. This likewise is not addressed to any specific person. WD–6 says:

> From the tempo of your letters it appears that health insurance is now your primary problem. If you deem it important enough every effort will be made to get Dr. Perrott and one or two others in this field on the mission.

And WD–7 says:

> Reur item 3. Since mission may arrive at time Wandel is about to return we believe it is desirable to consider Staten as replacement and possible to accompany mission.

Have you checked those?

Mr. COHEN. Yes, although I can't find it.

Senator DONNELL. I will be glad to show this to you if you need it in your testimony. I would like it back as soon as you are finished looking it over.

Mr. COHEN. Thank you, Senator. It was just misplaced here. I will now read WD–8. That comes in next.

Senator SMITH. Were there any replies to 6 and 7 relevant to this?

Mr. COHEN. Yes, there was an FEC item 6, reference WD item 7, which says:

> Would agree to having Staten included in mission. Any other potential successors to Wandel should also accompany mission.

Senator DONNELL. Mr. Cohen, just a moment before we get away from WD–6 and WD–7. Dr. Perrott, as you indicated the other day, is really not Dr. Perrott; it's Mr. Perrott, is that right?

Mr. COHEN. That is correct, Senator.

Senator DONNELL. Now Miss Mulliner, who was present during the teleconversation to which you prefer, Miss M. Mulliner was formerly employed in the office of Senator Wagner, was she not?

Mr. COHEN. That is correct, sir.

Senator DONNELL. Senator Wagner of New York, is that right?

Mr. COHEN. Yes, Senator.

Senator DONNELL. Now why was it particularly desirable, if you know, and I quote WD–7 which originated here in Washington:

> To consider Staten as replacement and possibly to accompany mission?

And before you answer that may I ask you first, is it correct that Mr. Staten was formerly assistant to Dr. Falk?

Mr. COHEN. Yes. In answer to your last question, Mr. Staten was, prior to my appointment as Assistant Director of the Bureau of Research and Statistics, the Assistant Director of the Bureau.

Senator DONNELL. Was he an expert in health insurance, if you know?

Mr. COHEN. No more than a general knowledge of the field.

Senator DONNELL. Then why was it particularly important, if you know, following WD–6 which says—

> It appears that health insurance is now your primary problem—

I say why was it particularly important to consider Mr. Staten as a replacement of Wandel if Mr. Staten was not an expert in health insurance?

Mr. COHEN. Well, first, as I said before, there was great difficulty, Senator, in getting anyone with even the most general knowledge of the social-security program recruited for these positions.

I cannot emphasize too strongly the amount of time I and other members of our staff took trying to encourage and enlist and persuade people to leave the United States and go to Tokyo, and be separated from their families for at least 1 year or perhaps longer because of the unavailability of housing in Japan.

Mr. Staten had come in one day to our office—I did not see him personally—and said, although I don't know what the exact reason was, that his position with Housing Authority no longer was as important or as necessary or was being abolished. I couldn't tell you what the reason was, but in any case he was personally available for any reemployment or employment in the social-security or related fields.

Senator DONNELL. You didn't hear him say that?

Mr. COHEN. No, sir.

Senator DONNELL. That was relayed to you by someone else?

Mr. COHEN. Yes, Senator.

Senator DONNELL. Who was that?

Mr. COHEN. That was Mrs. Merriam.

Senator DONNELL. All right.

Mr. COHEN. I then said to her quite on the spur of the moment, "Well, perhaps he would be willing to go on the Japanese assignment if he is footloose and free and had severed connections with previous employment. That might be the kind of case in which an individual would take the assignment."

I urged her to write to Mr. Staten and have him communicate with Major Simmons, which I understand he did. He wrote to Major Simmons, and I asked him to do so, so that the communication would be direct with the War Department, because Mr. Staten was no longer a member of our staff.

Senator DONNELL. Pardon me, Mr. Cohen, but at this point, is this the Francis A. Staten who was assistant regional director for management, Federal Public Housing Authority?

Mr. COHEN. I believe that was his position, sir.

Senator DONNELL. Particularly I wanted to ask you that, because in the letter I read into evidence the other day from Mr. Harness to the Honorable John Taber, September 9, 1947, the name of Mr. Staten, with the official designation to which I referred, is included, but the spelling of it is F-r-a-n-c-e-s. which I thought was a feminine name, and I assume the correct spelling is F-r-a-n-c-i-s.

(The letter referred to appears on p. 1994.)

Mr. COHEN. That is correct, Senator.

Senator DONNELL. All right.

Mr. COHEN. To merely conclude our inquiries about Mr. Staten, from that point onward, at least, I had no direct contact with the further conversation of Mr. Staten, except that Major Simmons would call me repeatedly and would say, "We have just got to get somebody who will be able to take over when Mr. Wandel's term expires. You haven't been able to suggest anyone else. The Tokyo people are urgently in need of someone. Why not have Mr. Staten go over?"

We made somewhat the same comments, I believe, that you implied—that Mr. Staten was not primarily an expert in the health problem; but he had, in terms of his background and in knowledge of the social security field, an excellent background in general on all parts of the social-security program and was particularly a person who was a good supervisor who knew how to work a team of people together in a cooperative way, and we therefore said that, in terms of the available people, we would certainly, in the absence of other people, recommend Mr. Staten.

It was for that reason, I believe, that this item, WD–7, was inserted; and if my memory serves me correctly, that was written by Major Simmons, not by myself. He was concerned, in terms of his responsibility in Washington for supplying them with nominations of personnel, to try to get them to consider Staten as a possible replacement; and it was for that reason, I am sure, that he included that item in the teleconversations.

Senator DONNELL. Well, now, at the time that WD–7 was composed it was already known, as stated in WD–6, that from the tempo of your letters it appears that health insurance is now your primary problem; that is correct, is it not?

Mr. COHEN. Yes, sir.

Senator DONNELL. Well, was any endeavor made by any of you gentlemen, or by Miss Mulliner, to get in touch with any well-known authority on health insurance to go over on this mission, and particularly was there any endeavor to get into touch with such organization as the American Medical Association or other organization of doctors to get their suggestions as to who should be this person to go over to succeed Mr. Wandel?

Mr. COHEN. Senator, in WD–11, which we will come to later, we indicated that we would discuss this matter with Surgeon General Parran. In other words, as Federal officials when these inquiries came in on health insurance, we felt that rather than to be handled solely by us they should be considered by Surgeon General Parran, particularly their nominations and referrals of the question of Dr. Mountin and other persons.

Senator DONNELL. In fact, WD–11 says nothing about anybody except Dr. Mountin, does it?

> Reur item 8. Will consider Mountin. Will discuss with Surgeon General Parran.

Mr. COHEN. That is correct; but you will see, if you refer to WD–9, that Louis Reed's name was mentioned, who is an employee of the United States Public Health Service, and that we then said, "Do you have any other suggestions?"

Senator DONNELL. I am glad you mentioned WD–9 at this point. I think it might be well to put it in right here, because of its connection with the subject under discussion.

WD–9.

> Reur item 4. What would your reaction be to following individuals for work on health insurance: Sanders, Klem, or Louis Reed?

What Sanders is that?

Mr. COHEN. Barkev Sanders.

Senator DONNELL. Who is he?

Mr. COHEN. He is the person referred to in Mr. Taber's letter, I believe.

Senator DONNELL. He is Chief of the Health Study Division, Bureau of Research and Statistics, Social Security, is he not?

Mr. COHEN. The correct title is Chief, Health and Disability Division.

Senator DONNELL. He is directly under Mr. Falk?

Mr. COHEN. That is correct.

Senator DONNELL. I proceed now with WD–9. "Klem"—now who is Klem?

Mr. COHEN. Miss Margaret Klem. She is Chief of the Medical Economics Section.

Senator DONNELL. Works under Mr. Falk?

Mr. COHEN. That is correct, Senator.

Senator DONNELL. "Louis Reed"—who is he?

Mr. COHEN. He is an employee of the United States Public Health Service. I couldn't tell you his exact title.

Senator DONNELL. He is on Dr. Parran's staff?

Mr. COHEN. He is.

Senator DONNELL. I beg your pardon; Mr. Perrott's staff.

Mr. COHEN. Mr. Perrott's immediate staff, under the supervision of Dr. Parran.

Senator DONNELL. So the complete WD–9 reads:

> Reur item 4. What would your reaction be to following individuals for work on health insurance: Sanders, Klem, or Louis Reed. Do you have any other suggestions?

And that WD–9 originated here in Washington—the inquiry which was written by you yourself.

Mr. Cohen. I wrote that myself; yes, Senator. Major Simmons talked with me several times and said: "Can't you give some specific names that would give them some idea as to whether those are the right people to be considered illustratively or specifically"; and he said he was very insistent upon that, repeating it several times. So I sat down and wrote this communication here, without too much thought other than that it would be illustrative and suggestive, and I added that statement, "Do you have any other suggestions?"

Senator Donnell. Well, Mr. Cohen, you say you did it without too much thought? Wasn't this considered to be a matter of exceedingly great importance? Here you have communications between here and Tokyo on the question of personnel on this important mission to Japan, and yet you make these suggestions of Sanders, Klem, or Louis Reed, who previously appeared in the testimony in this matter, by the way—quite frequently, at least, some of them have—and you made those suggestions without too much thought; is that right?

Mr. Cohen. Yes, Senator; that's what I said. Here is what I meant by that: It had to be done within a minute or two, from the time that Major Simmons asked me to the time that I completed it. I only meant to imply that I did not have sufficient time in my own mind to completely review all of the possible candidates that might be considered.

Senator Donnell. Well, Mr. Cohen, there was no obligation on you to decide a matter of this great importance in a minute or two, was there?

Mr. Cohen. No, sir.

Senator Donnell. And if I may call it to your attention, in WD-11 you obviously didn't decide that matter in a minute; because you said, or somebody said: "Will consider Mountin. Will discuss with Surgeon General Parran."

Mr. Cohen. Yes, Senator.

Senator Donnell. Then what was the reason for this great haste in suddenly deciding, as you have indicated here, within a minute or two the names Sanders, Klem, or Louis Reed for work on health insurance?

Mr. Cohen. They were the three people, Senator, who came to my mind on such short notice who had some knowledge and background in the field of health insurance.

Senator Donnell. You knew that these were all very close to Mr. Falk, did you not—Sanders, Klem, and Louis Reed?

Mr. Cohen. Well, I knew that Sanders and Klem worked for Mr. Falk. But I didn't know that Mr. Louis Reed was close to Mr. Falk. He is not employed by him.

Senator Donnell. You knew that Mr. Louis Reed was on the research staff of 11 members on the Committee on Costs of Medical Care, of which Mr. Falk was associate director?

Mr. Cohen. I knew he had been connected with the committee of which Mr. Falk was the associate director; yes, sir.

Senator Donnell. All right; go ahead.

Mr. Cohen. Well, I believe, Senator, that that completes—we have now read the relevant portions of these communications.

Senator Donnell. Well now, Mr. Cohen, I may have diverted your mind from WD-8. I think that should be read, too, do you not?

Mr. Cohen. Oh, yes; I am sorry, Senator.

Senator Donnell. You started to talk about that.

Mr. Cohen. That is what I started to do.

Senator Donnell. Would you mind going ahead with WD–8? All these WD's originated here in Washington in this conference which you participated in?

Mr. Cohen. Yes, Senator.

Senator Donnell. And the others, so we have it perfectly clear, were Miss Mulliner and Major Simmons?

Mr. Cohen. Correct.

Senator Donnell. That's right; isn't it?

Mr. Cohen. Yes, Senator.

Senator Donnell. And Major Simmons was with the War Department; is that right?

Mr. Cohen. He was with the Civil Affairs Division of the War Department.

Senator Donnell. And Miss Mulliner was with the Social Security Administration?

Mr. Cohen. She is the Executive Assistant.

Senator Donnell. And the same lady you mentioned awhile ago as having been in the employ, at one time, of Senator Wagner; is that right?

Mr. Cohen. That is correct, Senator.

Senator Donnell. Would you please read into the record WD–8?

Mr. Cohen (reading):

WD–8.

> Reur Item 4. We will then plan on mission to be composed of——

Senator Donnell. WD–8 isn't addressed to anyone?

Mr. Cohen. No, Senator.

Senator Donnell. Do you think it advisable before you read WD–8 to see what that word "then" refers to? Was there something back from Tokyo preceding the sending of WD–8 which leads you to say, "We will then plan"?

Mr. Cohen. My own impression, Senator, without tracing it too closely—I remember distinctly Major Simmons said, Well, we have just about come to the limit of our time on this teleconversation." It must have been some allotted time, and we'd better conclude what is more or less a summary of the report.

Senator Donnell. Are you able to tell us what had come back to you just before WD–8 was sent?

Mr. Cohen. Well, my impression—at least, the way I have them organized here—is FEC item 6, reference item 7, which ends, "Any other potential successors to Wandel should also accompany mission," which might explain why we then said, "We will then plan on mission," which was a sort of pulling together of threads of the conversation.

Senator Donnell. I call your attention to FEC item 6, which has another sentence, too, which says, after saying "REF item 7".

> Would agree to having Staten included in mission.

Then follows:

> Any other potential successors to Wandel should also accompany re mission.

That is correct, is it not?

Mr. Cohen. That is correct, Senator.

Senator DONNELL. So you think then WD–8 came after the receipt of FEC item 6; is that right?

Mr. COHEN. That would be my belief, Senator. It seems to be the logical sequence.

Senator DONNELL. All right; then proceed with the reading of WD–8.

Mr. COHEN (reading):

Reur item 4. We will then plan on mission to be composed of Dr. Perrott (if possible) and other health insurance men. Mission will arrive by——

Senator DONNELL. Pardon me just a minute. You are obviously there—it says, "Reur item 4." You are not replying to FEC item 6 are you? You are replying to FEC item 4 which you have already read into the record, are you not, when you responded in WD–8?

Mr. COHEN. Yes, Senator; you are correct. We are responding to FEC item 4.

Senator DONNELL. Which originated in Japan.

Mr. COHEN. Yes, Senator. We are now replying in effect to their item 4.

Senator DONNELL. Yes, sir; all right.

Mr. COHEN. In which, as you will recollect, they had indicated that it is urgent for the mission to arrive not later than September 1. That is how that item commences.

Senator DONNELL. Now read WD–8, please.

Mr. COHEN [reading]:

Reur item 4. We will then plan on mission to be composed of Dr. Perrott——

Senator DONNELL. Why was it you constantly referred to him as "Dr. Perrott," Mr. Cohen? You knew he wasn't a doctor, didn't you?

Mr. COHEN. Yes. In fact, I usually referred to him as "Mr. Perrott," so I am somewhat at a loss to know how that got in there. It may well be that I did not write that, or Major Simmons did.

Senator DONNELL. It got into WD–6 also; called him "Dr. Perrott" there. I don't suppose, of course, that you intended—and I mean this; this isn't sarcasm—you didn't intend, of course, to say this gentleman is a doctor, because he isn't a doctor.

Mr. COHEN. He isn't and I know very well that he isn't.

Senator DONNELL. You know very well that he isn't, and I am somewhat curious to know why that would appear in both of those items.

Mr. COHEN. I would say, Senator, in all frankness that I believe it was probably Major Simmons, because I think there is a tendency to refer to these people as doctors sometimes indiscriminately.

Senator DONNELL. We have got into that habit here—Dr. Murray over here. Go ahead.

Mr. COHEN (reading):

Mission will arrive by September 1. Will plan on Mr. Altmeyer coming at later date. Will cable names of members and request approval as soon as available.

What will Social Security Division report contain? Will it cover all aspects of social security or only health insurance and medical care? Please forward five copies of report by air mail by first week August if possible in order to assist in interesting right people to participate in mission.

(End of item.)

Senator **Donnell**. Now Mr. Cohen, right at that point, I notice in the way that it is typed here on my photostatic copy that that request to forward the five copies of the report by the first week in August, if possible, "in order to assist in interesting right people to participate in mission," immediately followed the inquiry as to whether the Social Security Division report will cover all aspects of social security or only health insurance and medical care. That is correct, is it not?

Mr. **Cohen**. Yes, Senator.

Senator **Donnell**. And I take it that the request for these copies in order to assist in interesting the right people was formulated with the point in mind that the persons to be on that mission should be people who were particularly qualified to handle whatever the subject matter of this report would be?

First, at the time there were going to be all aspects of social security, you would want somebody that was qualified along all aspects of social security; if it were only health insurance and medical care you would want somebody that was qualified along those lines. That is correct, isn't it?

Mr. **Cohen**. That is correct, Senator.

Senator **Donnell**. And that is the reason for the incorporation of that request in WD–8, is that right?

Mr. **Cohen**. That is right, Senator. You stated very correctly what was in my mind at that time as to whether the people that they were asking us to send should be people qualified extensively on the entire program or intensively on some particular feature of it.

Senator **Donnell**. And did you or did you not have in mind the fact that it would be of great importance, if this report were to relate to health insurance, that people that had what you thought were the right views on health insurance should be on that mission?

Mr. **Cohen**. No, Senator, that was the furthest from any thought that I had at the time.

Senator **Donnell**. You wouldn't have in any way attempted to put anybody on that mission because of the fact that he favored the views that you and Dr. Falk had with respect to health insurance?

Mr. **Cohen**. No, Senator, I certainly would deny that categorically because that was not in my mind at all as to their views on any of this matter. I was thinking of it in terms of people who had the background and knowledge on the particular areas that the people in Japan were concerned with.

Senator **Donnell**. And yet WD–9 which followed—how many minutes after WD–8 did you say WD–9 was sent?

Mr. **Cohen**. Oh, a couple of minutes.

Senator **Donnell**. And yet within a couple of minutes after you sent WD–8, which contained this request to send the copies of the report—

> In order to assist in interesting the right people to participate in the mission—

WD–9 was sent which said:

> What would your reaction be to following individuals for work on health insurance: Sanders, Klem, or Louis Reed? Do you have any other suggestions?

That is correct, isn't it?

Mr. **Cohen**. That is correct.

Senator **Donnell**. And did you have any idea at all what the views of Sanders or Klem or Louis Reed were on the subject of health insurance?

Mr. COHEN. Well, I have a good idea of what Mr. Sanders' views are, but I would say my knowledge of what Miss Klem's views and Mr. Reed's views on these matters is very—well, I will put it this way: I have never specifically asked them or discussed with them their particular views on health insurance per se.

Senator DONNELL. Well, you know what Dr. Falk's views were at that time on health insurance?

Mr. COHEN. Yes, sir.

Senator DONNELL. He had delivered speeches, great numbers of them, and written great numbers of articles which he has very kindly put into this record, I mean the list of them. You knew without any doubt that Dr. Falk is firmly convinced of the desirability of compulsory national health insurance; you knew that, didn't you?

Mr. COHEN. Yes, sir.

Senator DONNELL. And you knew that Sanders, Klem, and Louis Reed had had previously these various connections with Dr. Falk which had been referred to earlier this morning in the testimony?

Mr. COHEN. Yes, sir.

Senator DONNELL. You knew that when WD–9 was written, did you not?

Mr. COHEN. Yes, sir. May I say something on that point?

Senator DONNELL. Very well.

Mr. COHEN. That general line of questioning to my mind seems to imply that anyone who was connected with Dr. Falk had no personal ideas or integrity of his own. I have been connected with Dr. Falk for a long period of time. That doesn't necessarily mean that every single idea that Dr. Falk has is immediately reflected in my mind.

These three people that I mentioned and myself, we consider ourselves people of professional ability and integrity and it does not mean that merely because Dr. Falk has some particular idea, that our association with him automatically means that we reflect his point of view 100 percent, and I think that in fairness to these three individuals it is my personal impression and my conviction that these three people are people of ability and professional ability and integrity, irrespective of whether their ideas happen to agree with mine or not.

I am sure that on many points—I am quite sure of this, Senator, on points that I happened to discuss with them—that if these three persons and myself will get into the same room together, we would not agree on many important things.

Senator DONNELL. You knew at the time that WD–9 was prepared that Louis Reed had written a book entitled, "Health Insurance, the Next Step," published in 1936 or 1937, did you not?

Mr. COHEN. Yes, Senator.

Senator DONNELL. And you knew the general tenor of Mr. Reed as expressed in that book?

Mr. COHEN. Yes.

Senator DONNELL. You had read the book?

Mr. COHEN. I had.

Senator DONNELL. You knew the general views of Miss Klem, did you not, even though you hadn't specifically put her under oath or taken interrogatories or presented the question to her? You knew how she felt on this subject?

Mr. COHEN. No, sir, I do not. I have never discussed the matter with Miss Klem as to her views on health insurance. I have discussed many times her views on voluntary prepayment plans on which she has done a great deal of work, but I have never asked Miss Klem whether she is or is not in favor of compulsory national health insurance program.

Senator DONNELL. Who caused Miss Klem to be appointed to the position, do you know?

Mr. COHEN. I could not say, from my own knowledge.

Senator DONNELL. Do you have any ideas, any opinions on that question as to to who caused her to have her present position?

Mr. COHEN. No, sir.

Senator DONNELL. Over how long a period of years has Miss Klem been associated in her professional capacity with the work conducted by Dr. Falk and under his superintendence?

Mr. COHEN. I don't know exactly, but I would say, 5, 8, 9 years, something on that sort.

Senator DONNELL. The Committee on the Costs of Medical Care—that was way back in 1928 to 1932, was it not?

Mr. COHEN. Yes, sir. I thought you referred to the connection with social security.

Senator DONNELL. You knew, however, back in 1928, 1932 or thereabouts when Dr. Falk was the associate director of the study conducted by the Committee on Costs of Medical Care that Miss Klem was on his research staff. You knew that, didn't you?

Mr. COHEN. I knew that, Senator.

Senator DONNELL. And you knew, did you not, that in the book entitled, "Medical Care for the American People," at page—I don't see the page. There is an administrative staff listed here under which is a research staff headed "I. S. Falk, Ph. D., associated director of study," under which is listed the personnel of that research staff, and two of the three persons whom you recommended in this WD–9 are listed in that staff, namely, Margaret C. Klem and Louis S. Reed, Ph. D. You knew that, didn't you?

Mr. COHEN. Yes, Senator.

Senator DONNELL. The date of this book, by the way, is November 1932. That is 15 years ago, so you know that Miss Klem had been associated in work with Dr. Falk for at least 15 years, or approximately that, prior to the sending of this WD–9. You knew that, didn't you?

Mr. COHEN. Yes, Senator.

Senator DONNELL. And did you know just what type of work she had done over all this period with him?

Mr. COHEN. I had no knowledge then nor do I have any knowledge of what her work was during the Committee on the Costs of Medical Care with Mr. Falk; no, sir.

Senator DONNELL. Well, now let's see. Dr. Falk continued with that organization only until 1932 or 1933, that is correct isn't it?

Mr. COHEN. Yes, sir.

Senator DONNELL. And Miss Klem was with him at that time. Now when he left there, do you know where he went?

Mr. COHEN. Where Mr. Falk went?

Senator DONNELL. Yes.

Mr. COHEN. I don't know where he went immediately. My knowledge is that some time later on he went with the Milbank Memorial Fund.

Senator DONNELL. Was Miss Klem associated with that organization, do you know?

Mr. COHEN. I do not know.

Senator DONNELL. You do not know and I don't know either, but you do know that later on she became employed in the department headed up by Mr. Falk. You know that?

Mr. COHEN. That is correct, sir.

Senator DONNELL. And she is employed in that department this very minute?

Mr. COHEN. That is correct, sir.

Senator DONNELL. What is the salary that she receives, do you know?

Mr. COHEN. I can supply that for the record.

Senator DONNELL. Well, approximately what, if you know about what it is?

Mr. COHEN. Oh, I would say it is approximately $6,000, but I would be glad to put the correct figure in the record.

(Mr. Cohen subsequently supplied the figure of $6,623.40.)

Senator DONNELL. All right, if you would be kind enough to do that. Thank you. Do you know how many years Mr. Falk and Doctor—I am using the term in the sense of Ph. D.—Louis S. Reed mentioned in WD–9 had been associated?

Mr. COHEN. I know nothing first-hand of Mr. Reed's association with Mr. Falk during the Committee on the Costs of Medical Care, but I do know he was employed in the Bureau of Research and Statistics very soon after its organization, and I believe——

Senator DONNELL. That is the Bureau headed by Mr. Falk?

Mr. COHEN. Yes. At that time it was not headed by Mr. Falk. I am speaking of the time when Mr. Falk, I believe, was then chief of the Health Studies Division. Mr. Reed was an employee of the Bureau of Research and Statistics at a time when Mr. Falk was not the director of the Bureau of Research and Statistics.

Senator DONNELL. Mr. Falk didn't discharge him at all, did he, as far as you know?

Mr. COHEN. That you would have to ask Mr. Falk.

Senator DONNELL. Well, he has been employed right along with that Bureau, has he not?

Mr. COHEN. No, sir.

Senator DONNELL. A considerable period of time, at any rate?

Mr. COHEN. Yes, but Mr. Reed is no longer—he severed his connection with the Bureau of Research and Statistics and is at the present time employed in the United States Public Health Service.

Senator DONNELL. Very well, but for a period of years after Mr. Falk was in that service Mr. Reed was employed, was he not, in that bureau?

Mr. COHEN. That is correct.

Senator DONNELL. Yes; and was directly under Mr. Falk and associated with him in work. That is right, isn't it?

Mr. COHEN. You say directly under him?

Senator DONNELL. Well, if not technically, he was closely associated with him, working with him right along?

Mr. COHEN. Yes, sir.

Senator DONNELL. When was it that you read this book by Mr. Reed entitled "Health Insurance, the Next Step"?

Mr. COHEN. Oh, I would say it was published in 1937 or 1938, somewhere in there, and I believe that I read it very shortly after it was published.

Senator DONNELL. You never heard of Mr. Reed changing his view on the subject in the book, have you; in any material respect?

Mr. COHEN. Well, I couldn't say that, because there has been some discussion as to whether Mr. Reed has or has not changed his views.

Senator DONNELL. Well, at any rate, Mr. Reed—you know, generally speaking, that he is an adherent to the view that national health insurance is a desirable thing. You know that to be true, do you not?

Mr. COHEN. I do not, Senator, and my own impression, if I may say so quite honestly, has been in the last year or so he is not such an adherent. You would have to ask him. My impression is purely personal. I can only say that in this sense, that in my discussions with Mr. Reed I have personally felt, whether it is right or wrong, that he has changed his mind in some material respect, but I have never asked him.

Senator DONNELL. Well, now I think you are correct on that. Can you tell me when he made that change, about how long ago? When did you learn about it?

Mr. COHEN. I didn't learn about it. I sensed it, Senator, in my discussions with him on various work that I have had to do with him, that he had certain attitudes, reservations, or changes in his thinking which he did not disclose to me, and I didn't ask him point-blank what they were.

Senator DONNELL. I see.

Mr. COHEN. I have had lunch with Mr. Reed several times. We have talked about a number of things, but I have never asked him whether he still believes in everything he wrote in that book.

Senator DONNELL. Your impression is, though, very clearly that he had changed in some respects from what was in that book?

Mr. COHEN. That is correct.

Senator DONNELL. But at the same time you knew that he had been associated with Mr. Falk over a period of years; that is correct, is it not?

Mr. COHEN. That is correct, Senator, but the thing that I had in my mind was not his attitude as to whether he was for or against health insurance, but that it is my impression from my contacts with him that he is a competent person first in this field with a lot of detailed knowledge, and that he could make a contribution to the technical work in Japan.

Senator DONNELL. Well, I think you are quite correct in regarding the change in view of Mr. Reed. I didn't recognize the name "Louis Reed" when I commenced to interrogate you, but I happen to have some information in regard to Mr. Reed, and have myself, if he is the gentleman I think he is, talked with him, and if that is the man there has been a very decided change in his views, as I understand it.

Mr. COHEN. Well, Senator, doesn't that in part—I wouldn't say prove—but at least indicate that there was not in my mind at the time the thought as to what these persons' views per se were on compulsory health insurance?

I was aware, I feel myself that Mr. Reed's views have materially changed; but, as I said, I didn't ask him; but I didn't feel that I was nominating or suggesting candidates who reflected my point of view. That was farthest from my thoughts.

Senator DONNELL. I am unable to answer your question because I don't know the date when Mr. Reed began to change his views. I have no knowledge on that, or at least I do not recall. I may have some information on that, however, and will be very glad to look it up in my file.

Senator MURRAY. On that question there, if you had learned that he had completely changed his views, you still would have recognized him as a man competent to work in that field?

Mr. COHEN. Why, yes, Senator. I feel that the attitude on compulsory health insurance was somewhat irrelevant to the consideration of these names.

After all, Japan has had a health-insurance system. It wasn't a question of sending someone over there who was going to be in favor of health insurance to force a system of health insurance upon the Japanese. They enacted such a law in 1922, put it into effect in 1927, and have what is probably one of the most comprehensive health-insurance programs of any country in the world, so there was no thought in my mind, nor do I think in anyone's else's mind, of selecting a person who is such a firm advocate of compulsory health insurance that he would persuade the Japanese people to enact a program which they did not have.

Rather, the thought that was in my mind to have someone who knew of the technical elements of health insurance and could help them in reconstructing and reorganizing the Japanese program. It seemed to me that the kind of person that should go on that trip was someone who was familiar with the problems of health insurance, with the technical problems related to eligibility and financing and administration; and those were the considerations that were in my mind; and it was not the attitude of the person as for or against compulsory health insurance.

Senator DONNELL. May I ask you in regard to Mr. Sanders, whether or not Mr. Sanders—his official title is Chief of Health and Disability Studies, is that correct, under the Bureau of Statistics?

Mr. COHEN. That is correct, Senator.

Senator DONNELL. How long has he occupied the position of Chief of Health and Disability Studies?

Mr. COHEN. I can tell you in just a second. It's been a number of years. He became the Acting Chief, according to our information here, sometime early in 1940.

Senator DONNELL. 1940, and consequently he worked quite closely with Mr. Falk?

Mr. COHEN. Yes.

Senator DONNELL. I am not implying his opinion, but he is thrown constantly in touch with Mr. Falk?

Mr. COHEN. Mr. Falk is his immediate superior.

Senator DONNELL. And he had been associated in that connection for approximately how many years?

Mr. COHEN. That would be 7 or 8 years, approximately.

Senator **Donnell**. Now, with respect to Miss Klem, do you know whether or not she has studied medicine or has taken any degrees in medicine, or in economics, for that matter?

Mr. **Cohen**. I couldn't say, Senator.

Senator **Donnell**. She does have an A. B. degree, does she not, or do you know about that?

Mr. **Cohen**. I believe she does, and my impression is that she is also a lawyer, that she is a member of the bar.

Senator **Donnell**. Where is she a member of the bar, do you know?

Mr. **Cohen**. I don't know myself. I am informed it is New York State, but I don't know of my own knowledge.

Senator **Donnell**. You don't know that of your own knowledge?

Mr. **Cohen**. No, Senator.

Senator **Donnell**. That's all. Go right ahead. Had you finished what you were saying?

Mr. **Cohen**. I was just going to conclude now, Senator, with a general statement, perhaps somewhat repetitive but in conclusion to my general remarks on this subject.

Senator **Donnell**. All right.

Mr. **Cohen**. I would like to say, therefore, Senator, that in conclusion I can state without any qualification whatsoever that representatives of the Social Security Administration were extremely reluctant to go to Japan because I have pointed out they felt it would impair the work in their offices and because it would separate them from their families; that Mr. Altmeyer was very reluctant to form such a mission; and that he stated to me several times that he would only do so if there was an indication that General MacArthur thought it was important and would contribute to the satisfactory carrying out of General MacArthur's responsibility.

At no time in any of the discussions on any aspect of the Japanese situation was there any attempt on my part or on the part of anyone that I know of to utilize the situation to influence the War Department or any of its representatives in connection with the selection of personnel for formulation of the project or aiding in the study of social security in Japan.

Insofar as I am personally concerned, I can deny completely that there was any interest or attempt in any way to influence the character of the project, the selection of the personnel, or the comments, conclusions, or opinions of any person participating in the work in Japan.

As far as I know, any charges that there was any conspiracy or plot to force any program of health insurance or socialized medicine on the Japanese people is absolutely without foundation and is untrue.

The entire basis for our participation in the Japanese mission was an attempt to be helpful to General MacArthur and his officials in carrying out their official responsibilities. There was at no time any attempt to prejudice the representatives of SCAP in any way, shape, or manner; and any inference or statement that the mission was conceived to accomplish some predetermined objective of an undercover character is absolutely without any foundation whatsoever.

Senator **Donnell**. May I ask you this one question, Mr. Cohen, please? You have referred now to WD-9, which has been read into the record. That one says:

> What would your reaction be to following individuals for work on health insurance: Sanders, Klem, and Louis Reed? Do you have any other suggestions?

Did you receive in this conversation FEC item 8 in response to that?

Mr. COHEN. Yes, sir.

Senator DONNELL. It reads, "Reference Item 9," does it not?

Mr. COHEN. Yes, sir.

Senator DONNELL [reading]:

> Reaction favorable to Sanders, Klem, and Reed. No other suggestions at moment. Mountin previously suggested by Janis.

And then it is correct that your WD–11 entitled, "Reur item 8, WD–11," having originated in Washington, FEC 8 originated in Japan:

> WD–11. Reur item 8. Will consider Mountin. Will discuss with Surgeon General Parran.

Is that right?

Mr. COHEN. That is correct, sir. I think, not to extend the interpretation of these items at great length, but you will note that the Tokyo reply states that their reaction was favorable to these three persons mentioned, and they said, "No other suggestions at moment." They then made the suggestion of Dr. Mountin, at their initiative, and Dr. Mountin was one of the persons who finally went on the mission.

Senator DONNELL. Well, pardon me, they say that Mr. Janis had suggested him.

Mr. COHEN. I don't believe in this communication——

Senator DONNELL. I am reading from FEC item 8. Pardon me for interrupting. It says:

> Reaction favorable to Sanders, Klem, and Reed. No other suggestions at moment. Mountin previously suggested by Janis.

Is that right?

Mr. COHEN. Yes, sir.

Senator DONNELL. Who was Janis?

Mr. COHEN. Dr. Lee Janis is a medical doctor who was employed previously by the Public Health Service and who went to Japan and who, I believe, is still there in a position which, if my memory serves me correctly, is responsible for the health-insurance work of that division of which Mr. Wandel, when he was there, was the head or the supervisor.

Senator SMITH. I would like to know for the record here, Mr. Cohen, who finally constituted the mission, when did they go, and have they returned yet?

Mr. COHEN. Yes, Senator. The mission technically was to be headed up by Mr. Altmeyer, and I was to go with him, but neither Mr. Altmeyer nor I did go nor do we have any intention now of going.

The persons who did go were Mr. Wandel, who preceded the group and who became the Chief of the Division there temporarily during his stay, and later Mr. Sanders; Dr. Mountin, M. D.; and Dr. Burnet Davis, M. D. Those were the persons who went at that time, and Francis Staten, of the Housing Authority. Those were the people who actually went on the mission.

It was intended that subsequent to Mr. Altmeyer's return and my return from my vacation, when Mr. Altmeyer returned here, that we would then go to Japan to work primarily on those points other than health insurance which were not covered by this mission. There were many important problems connected with that; but, when Mr. Altmeyer returned to this country after his absence for several months in Europe, he felt that he couldn't give the time to it.

Senator SMITH. That was in August, was it, when he came back?

Mr. COHEN. I believe that is correct, sir.

Senator SMITH. And the mission had gone when? I just want to get the dates.

Mr. COHEN. The mission left on August 28; August 27 is the date that the War Department released its press statement concerning the departure.

Senator SMITH. The departure is that date?

Mr. COHEN. That is correct, sir.

Senator SMITH. And they stayed how long?

Mr. COHEN. They came back at different times. They didn't all come back together. I think they came back in—they did not come back together, but they came back sometime in the fall.

Senator SMITH. Well, we don't need the exact date. What I am trying to get a picture of is just what they accomplished. Did they help set up a national legislation to cover this matter in Japan and then was their mission completed and they returned?

Mr. COHEN. Well, Senator, they didn't set up anything. Their purpose in going there was to review the existing legislation and its administration and to make a report to the appropriate officials and ultimately to General MacArthur on the operation of the program and necessary changes to simplify, coordinate, and make it a more effective system as a result of the inflation and the dislocations of the war.

Senator SMITH. That report was made?

Mr. COHEN. They made a report to General MacArthur.

Senator SMITH. About when was the report made?

Mr. COHEN. The report was completed almost the same day that they left. In other words, the members of the mission had plane reservations to go. I can't give you the exact date now. It is the latter part of November—approximately in there.

Then the members of the mission came back and a copy of the report has been in the hands of General MacArthur; and he has sent a copy here to Washington, which is in the War Department, and he has sent copies to certain other persons. I have not myself attempted to get the report, nor have I read it, but I understand that it is in this country, although not generally available as a public document.

What action General MacArthur and SCAP take on that is a matter that I don't know of, but these persons had no responsibility for taking any action with respect to the program other than making a critical comment and report to General MacArthur and his staff.

Senator SMITH. They were then an advisory committee?

Mr. COHEN. They were.

Senator SMITH. I just wanted to get the chronology there as to just what happened.

Mr. COHEN. That's correct.

Senator SMITH. And that is the last chapter, for the moment?

Mr. COHEN. I believe if members of your committee are interested in the report—I have not read it or seen it myself—but I think if you are interested in it I would suggest that you address a communication to the War Department and ask for a copy of the report and it will speak for itself.

As I say, I haven't the slightest idea what is in it, but if you are interested in what they did or what they said or what their conclusions were, I think that you ought to have an opportunity to see it.

Senator MURRAY. Mr. Cohen. prior to the time that this subject or the mission to Tokyo was taken up by Dr. Marjorie Shearon here. She was the one who first raised any question with reference to this mission to Tokyo.

Mr. COHEN. The first I heard about it was in connection with some statement that she issued—that it would sooner or later become a matter of knowledge when further investigation would be handled by another committee.

Senator MURRAY. And the only purpose and intent that you or anyone else connected with the Social Security Administration had over there was merely to assist the War Department in this matter?

Mr. COHEN. Not only the War Department, Senator, but I think—I speak for myself as an individual citizen. I have been reading the papers and have some feeling for the tremendous responsibilities that General MacArthur has. the problem that he has out there, and the tremendous scope of problems of reorganizing the entire economy of Japan and when this request came to our attention I felt that as a citizen and as a public servant that I ought to do everything that I could to help. I spent many hours from my other work, which required a good deal of my overtime, in order to keep up with it, talking with people, trying to get them to go on this mission, and I may say it is a matter of deep regret to me that I have had to spend so much time from my other perhaps more important duties on this completely irrelevant matter of the Japanese mission which is being referred to in the press and speeches as a maneuver and a plot and a conspiracy, all of which is completely foreign to the facts and is a misrepresentation of what actually took place.

I don't know whether your committee, on the basis of what is before you, will come to the same conclusion, but it certainly has resulted in a great waste of official time on our part in the Social Security Administration—distracted us from other duties.

I think it has seriously affected the morale of our people, has caused in a way the esteem of public servants to be jeopardized, and I feel it was an extremely unfortunate circumstance.

I would for myself hope that the matter could be closed, because I feel that it has been a matter which was very unfortunately brought up on a mistaken basis, and the so-called statements concerning the mission which are being circulated as facts have been widely circulated everywhere, and as you gentlemen know, we were given no opportunity except in this forum to state our side of the case.

Incorrect statements were made by Members of the other branch of this Congress about myself, about Mr. Falk, about our organization, about our intentions. We were given no opportunity to reply to them.

I can only say to you gentlemen that, for myself I am very glad to have had the opportunity. You have been extremely fair and kind, and I am perfectly willing to rest upon the facts as brought out, but we didn't have an opportunity anywhere else to really tell our side of the story, and that is true about many of these other incidents, Senator.

They have been torn out of context, false motives have been read into things that we have done, misstatements have been made and I can only say, as a person who considers himself a public servant, that it hasn't been in the interest of either the respect for the legislative or the executive branch which I think the American people should hold for their public servants.

Senator MURRAY. You were familiar with all of the details connected with the arrangement to send this mission over to Tokyo and you know of no design on the part of anyone connected with your organization over there to try to foster anything or impose upon the Japanese people?

Mr. COHEN. No, Senator. As I said so many times, the fact that they had a health-insurance program of their own, the fact that there was so much reluctance on the part of anybody to go over there, and I begged many people to make personal sacrifices as far as family and job were concerned to try to meet the request of the War Department.

I spent many hours explaining to them what the conditions were, and talking with Major Simmons and with persons on our staff, and the result is a kind of personal vilification which, of course, has distressed me very much because I feel that there was no such motive in this whatsoever.

Now maybe the facts have not been made known heretofore to the Members of the Congress and the American people, but that is only because as public servants we have had no opportunity on our own to present the facts to anyone, and I hope that when the facts are known, this incident and many others will be equally brought to the attention of the people.

If you read as many medical journals and other documents as I have in which this matter is constantly referred to as a plot and a conspiracy and in one of the speeches that we are the center of a world-wide movement to socialize medicine, I can't tell you how much that distresses me because it is not true, and as public servants, if you want to call us that, as bureaucrats, what opportunity do we have, Senator, to defend ourselves in the public forum?

We have none unless a committee like this gives us an opportunity to do so.

Senator MURRAY. Sometimes when you do appear before some committees they don't give you very much of an opportunity either, do they, sometimes?

Mr. COHEN. Well, that is true——

Senator MURRAY. What do you think of the action of the Harness committee in handling this matter?

Mr. COHEN. Well, I will only make one statement. We were ready at any time and we wanted to be heard, but the Harness committee has never asked Mr. Falk or myself or Mr. Altmeyer or anyone that is connected with any of these incidents which have been discussed today to come up and present our side of the case, but reports have been issued, speeches have been made, and we have had no opportunity to present our side of the case.

Senator MURRAY. The propaganda that was sent out across the country was quite widespread, was it not? It started about the time that the Harness committee took up this matter for investigation.

Mr. COHEN. It started, of course, a long time before that, Senator. The Harness committee I think merely picked up a lot of other information that was circulated around, a lot of other statements and took them as facts without any public hearings, cross-examination, as this committee has done, and has continued to circulate them.

Senator MURRAY. My understanding is that this Dr. Shearon, who has been an advisor of this committee, is the one who claims to have first discovered this plot and arranged to bring it before the Harness committee, and we have read into the record here just day before yesterday when the hearings were on, a document which she sent out to the medical profession in the country in which she claimed to be the one who discovered this plot and instigated the hearings over in the Harness committee. Did you see that statement that she put out?

Mr. COHEN. Yes; I did, Senator.

Senator MURRAY. What do you think of the truth of that statement?

Mr. COHEN. Well, I don't think there is any truth in that statement any more than there is very much proof in a lot of other material Dr. Shearon gets out. One can, of course, as you gentlemen know, take an item out of context from statements or actions or activities and by piecing it together make it look like something different from what it really is.

It occurs all the time in human activity, and I don't say that as public servants we don't recognize that we are going to be criticized. Legitimate criticism, of course, if deserved, is important, but I feel personally that not only is much of it illegitimate with respect to myself and my colleagues personally, but it is an attack upon the integrity of public servants .

You cannot run government, Senator, unless you have human beings to run government, and if there is continued attack on public servants as there has been recently, I don't see how Government in this country can continue to run.

You have got to have people to do it. We all make mistakes. Congress has the ultimate responsibility of supervising our activity, but I say in all fairness that continued personal vilification, attack of motives and so on, is not conducive in a democracy to the respect to which people should hold their Government officials whether they are Congressmen, Senators, or bureaucrats, and that is what bothers me more than anything else.

I have been up here 13 years now, and I have spent most of those 13 years working with Members of Congress in legislative activity. That is how I got into most of this legislative work in connection with social security.

I have learned in that time that people have different opinions. They are aired out on the floor of Congress. I have respect for people who have opinions different than I do. I work with many committees—this committee, the Ways and Means Committee in the House, the Senate Finance Committee in which I have been asked as a professional person, as a technical person with some knowledge of legislation, to prepare bills which were not in accordance with my views.

I do that; I have done it continually working with Senators on changes in social security legislation, but to imply some ulterior motive to what you have done I think is extremely unfair and unfortunate.

Senator MURRAY. If a Senator requested you to make a proposed amendment to a bill which would totally change its purpose, you would furnish him with that material?

Mr. COHEN. Not only would I, Senator; in the 13 years I have been here I have prepared amendments and worked up materials for Senators on both sides of the aisle on matters which our Department had taken a position opposed to. We have always taken the position that we are ready to render any assistance to any Member of Congress or any committee. That is what we were doing for you when you were chairman of the committee; that is what we would do for the present chairman or any member of the committee. We would be delighted to assist in any way that we can to help in improving our present legislation.

Senator MURRAY. You think it is unfortunate that this committee has to be imposed upon with matters of this kind that are wholly irrelevant to the question involved and which are designed to discredit the program of national health insurance which has been put before the Congress?

Mr. COHEN. Yes, Senator. As you know, in the so-called five-point national health program recommended by the President in his message, health insurance is only one part of the matter.

I mean there is improvement of the public-health program, the maternal and child-health program, medical education and research, and the addition of temporary and disability insurance.

I think that, irrespective of one's attitude on some of these controversial matters, there is a great deal that can and should be done in the field of health, but unfortunately controversy over some of these other matters has, in my opinion, held back the progress on the noncontroversial items, and I think if this committee and the committees in the House had given the same time to the substantive consideration of the bills, we might have been able to make more progress, but that is just my personal opinion. I only see it as an official in our own organization.

We have been distracted; time and our energy and our staff members have been taken off of really important technical work, answering requests and preparing information for this hearing. The morale of the staff is sometimes seriously affected. Everyone is afraid to put anything down on paper because Mrs. Shearon will get hold of it and distort it, and that, irrespective of its merits, I say to you gentlemen, is not a healthy condition for a career service.

I only hope that no matter what your attitude on this investigation is, that something can be done in the legislative field. Let bygones be bygones and let's start over so that we can spend our time on the some constructive aspects.

Senator MURRAY. This Dr. Shearon who has been responsible for this propaganda that we are talking about has been able to maintain an office right here in the Senate Office Building from which she sends out literature of this kind designed to discredit the men in your agency over there and discredit the proposed legislation in every manner possible.

You know that. She's had this office here in the Senate Office Building for some time carrying on this propaganda.

Senator SMITH. Just at that point, Dr. Shearon has not an office here now.

Senator MURRAY. Well, I mean to say during the course of the hearings that we had here up until very recently she maintained that office here and was in the employ, I understand, of the National Republican Committee, and at any rate she is going to testify in a day or two and she will tell us exactly whom she was representing, but the character of the propaganda that she sent out obviously was intended for the purpose of deceiving the public, and even deceiving the medical profession of this country with reference to these matters.

This confidential statement that she sent out on August 20, 1947, by its very language indicates that. It reads:

> Confidential, for subscribers only; not to be shown to anyone else; not to be released to the press. This story will not break for several days. The leads were mine. The follow-up investigation has been done by the Harness subcommittee and I do not wish to steal their thunder. I am sending this in the hope that some of you may be in the position to act before August 28.

Then the article goes on to impugn the motives and honestly and integrity of everybody connected with that mission to Moscow—mission to Tokyo. [Laughter.]

Well, it is obvious that the whole purpose and object here is to try to discredit the National health bill pending in the Congress, and for that purpose only.

Mr. COHEN. Your statement about Moscow, Senator, I think is relevant in this respect. Many of the statements put out attempt to show a connection between these activities and the Communist Party line.

Senator MURRAY. Yes.

Mr. COHEN. I can't tell you what the Communist Party line is. I am not a Communist. But I certainly resent as an American citizen—and a patriotic American citizen—the constant reference to what the Communist Party line follows on this program of compulsory health insurance and to our activity and its relationship to the ILO. Because again that whole attempt to show that type of tie-up is absolutely without any foundation—I speak not for myself only, but I think I speak for other persons—and is an attempt again to throw into public criticism and disrepute the public servants of the United States.

Now if there is any truth in those statements, I think they should be investigated by Congress and something done about it.

Senator DONNELL. Might I interrupt there at this point, Mr. Cohen? You mentioned the ILO. That is the International Labor Organization, isn't it?

Mr. COHEN. Yes, Senator.

Senator DONNELL. Is it a fact that in 1945 and 1946 that that organization had a special committee on seafarers' insurance? Mr. Falk was appointed by the United States as an expert and represented the United States at the London conferences in July of 1945 of that organization.

Mr. COHEN. I don't remember the exact date, but it is correct that Mr. Falk was an adviser, and Senator, I was later the United States adviser on social security to the ILO conference in Seattle, Wash., at which those recommendations and conventions were discussed.

Senator DONNELL. That was in June of 1946, wasn't it?

Mr. COHEN. June of 1946; yes, sir.

Senator DONNELL. Then there is nothing at all reprehensible in mentioning the fact that you gentlemen have had some contacts with the International Labor Organization, is there?

Mr. COHEN. Oh, no, sir. We have had a great many contacts with the ILO in its official connections, but I believe there was reference to it here earlier in the discussions, an article that was published in Medical Economics about—I don't have it before me right now—about the whole world-wide conspiracy of the ILO and ourselves in trying to foster a system of socialized medicine.

Senator DONNELL. Well, I thought you were rather resenting a few minutes ago any mention of the connection or contacts with the ILO, and I don't know just what your thought was in that connection, but as a matter of fact you gentlemen have had the contacts to which you referred yourself in your testimony just now; that is correct, isn't it?

Mr. COHEN. Absolutely, Senator, and if there was any implication in what I said, that we had no connections with the ILO, I certainly did not so intend.

Rather, I meant that this article and other articles about the connections with the ILO, such as appeared in Medical Economics in 1945, attempt to show some type of—you might call it—interlocking directorate or conspiracy. Whereas I believe you implied that the ILO is an organization to which the United States Congress has given its official legislative authorization for our affiliation, and our connections as United States Government delegates or advisers is pursuant to that authorization, and under the authority of the Secretary of State, we go to these conferences.

I may say on many of these points, if you would like to go into this whole ILO relationship, we would be only too glad to give you our full side of the story because there are many things in this article—what Mrs. Shearon has said about our relationship in the formulation of the ideas on medical care in connection with the ILO—which are half-truths and misleading.

Senator DONNELL. This article; who is the author of the article to which you refer?

Mr. COHEN. The article is not signed, Senator.

Senator DONNELL. You are not implying that that is an article by Dr. Shearon, I take it?

Mr. COHEN. I have reason to believe that Dr. Shearon had some part to play in the writing or preparation or assisting in or cooperating in the writing of this article.

Senator DONNELL. Did she ever tell you that she had any connection with it?

Mr. COHEN. No; Senator.

Senator DONNELL. Now referring to the International Labor Organization, there is a permanent Inter-American Committee on Social Security in that Organization, is there not?

Mr. COHEN. It is not technically in that organization, Senator. That is a separate organization, the Secretary General of which is a member of the ILO staff, but it is an autonomous, separate organization.

Senator DONNELL. It meets at the same time with the International Labor Organizaton, does it not?

Mr. COHEN. No; Senator. You are talking about——

Senator DONNELL. The permanent Inter-American Committee on Social Security.

Mr. COHEN. No; Senator. It meets completely independently and separately and it has, as I stated, for its secretary-general a member of the ILO staff and the ILO sends a tripartite delegation representing employers, employees, and the governing body to the meetings of the committee and the conference, but the conference is its own supreme authority in its field.

Senator DONNELL. Now Mr. Altmeyer is the United States delegate to what? Is it to the International Labor Organization?

Mr. COHEN. No; sir.

Senator DONNELL. What is it to?

Mr. COHEN. Mr. Altmeyer was the United States delegate to the first meeting of the Inter-American Conference on Social Security held in Santiago, Chile, in 1942, and the United States delegate again to the most recent conference, the Second Inter-American Conference on Social Security held in Rio de Janeiro last year.

He is also, having been elected by the Conference, the chairman or president of the Inter-American Committee on Social Security which is the continuing sort of executive body of the conference and which only meets periodically.

Senator DONNELL. Well, what connection, if any does Mr. Falk or yourself have with the International Labor Organization? Do you have any?

Mr. COHEN. We have had quite a number of connections, yes, Senator.

Senator DONNELL. Well, official connections?

Mr. COHEN. Well, I will speak for myself first. I was, as I pointed out to you a few moments ago, a United States adviser to the United States delegation at the Seattle Conference of the ILO which handled social-security matters relating to the maritime problem.

I was appointed to that position by the Secretary of State and in my work there I operated under instructions issued by the Secretary of State. I attended and have attended a number of meetings of the ILO, particularly the 1944 meeting of the ILO held in Philadelphia.

Senator DONNELL. Montreal?

Mr. COHEN. Yes. I was going to speak of the Philadelphia one first.

Senator DONNELL. All right.

Mr. COHEN. The Philadelphia one in 1944, which Conference adopted certain recommendations relating to social security and medical care.

Senator DONNELL. Those are the recommendations which appear in the report IV (1) of International Labor Conference, twenty-sixth session, at page 101 and following under the title: "Proposed Recommendations Concerning Medical Care;" is that right?

Mr. COHEN. Yes, sir. I just wanted to say those are the recommendations as submitted to the Conference. Those are not the recommendations as adopted by the Conference.

Senator DONNELL. They were submitted to the Conference?

Mr. COHEN. They were submitted and these were the documents that were considered. Now I would like to say, Senator, since you brought it up, because it is extremely important in connection with the misinformation that has been given out—and I won't take the time to go into all the aspects unless your committee does want us to go into it, but it has been stated or implied, referred to several times, that Dr. Falk and myself, who attended this Conference as advisers to Mr. Altmeyer——

Senator DONNELL. You are speaking of the Montreal Conference now?

Mr. COHEN. Now I am speaking of Philadelphia, in which this document that you referred to was considered.

Senator DONNELL. Pardon me just a minute. It appears, however, that the publication which is on the front page of it says, "ILO Montreal International Labor Office, 1944," but it relates to Philadelphia?

Mr. COHEN. Yes, sir. This is what was developed and printed by the ILO in Montreal and sent to the delegates of all of the countries that attended, for consideration at the Philadelphia meeting in 1944.

When we arrived there this was submitted or it had been sent to us previously. This was the document for consideration, and as you notice it consists of two main parts—an income-security recommendation and a so-called medical-care recommendation.

Now, if I may, I would like to take up the medical-care recommendation, because that is the one to which I believe you were referring, not the income security. Now, in the case of the medical-care recommendation, it has been repeatedly referred to that the delegates adopted this medical-care recommendation, embracing detailed proposals to guide the member states in developing their health services, and that a majority of the 114 proposals are embodied directly or by implication in the Wagner-Murray-Dingell bill of 1945, and so on.

Now, the fact is, Senator, that Mr. Falk and myself at this conference were largely responsible for opposing this recommendation on medical care, criticizing it and recommending to Mr. Altmeyer the abstention of the United States Government when voting on this recommendation on medical care.

Mr. Altmeyer concurred in that recommendation and transmitted it to Miss Perkins and to Senator Thomas of Utah, who were the two United States Government delegates, and the United States Government, based upon Mr. Falk's recommendation and my recommendation, ultimately abstained from voting in favor of this recommendation, so that the United States' position on this matter of medical-care service, contrary to the general implication that we urged its adoption by the ILO and is the basis for the Wagner-Murray-Dingell bill and for our circularization of their ideas, has never been endorsed by the United States Government, was not approved by the United States Government, and, on the contrary, the recommendation for the United States Government's abstention was based initially on Mr. Falk's and my recommendation to do so.

Those facts have never been brought out in public. It is made to appear as if we were the ones who prepared, endorsed, affirmed, circulated these recommendations in a world-wide attempt to influence medical care. Mr. Falk and I have written many memos, we talked with members of the ILO staff, urging them and criticizing this draft as not being in accordance with American thinking, American ideas, or sound policy.

As you will see, I brought along this morning my own copy of that time and you will see from it here—this is the copy that I was considering. I blocked out whole sections of this as being inappropriate, inadvisable, and unacceptable to the United States Government.

Yet it is made to appear in all these documents that it is our brain child and that we were fostering and circulating it. That is just an indication of how misinformation on our motives and our ideas is being circulated when they are the furthest from the truth.

Senator SMITH. Mr. Cohen, I want to state for myself that I am very glad you have had the chance to make the full statement you have made this morning. I hope you feel you have had full opportunity given to you by this committee to do that.

You mentioned a little while ago that you had, and I want you to feel you have had every opportunity. I want to say also that I don't want the impression to be given that this committee is criticizing ILO. Personally I feel it is one of the finest products of the League of Nations set-up originally.

I have followed their work carefully. I think the way they meet and have management and labor discuss these matters—make their recommendations back—they have no legislative authority—all they can do is make recommendations back, and I am glad we have been able through our distinguished colleague, Mr. Elbert Thomas, of Utah, to be represented at those conferences with such members as he took along with him. I think he has done it in a splendid way.

I want to be on record as one of those who believe in what the ILO is doing. It may frequently pass resolutions which you or I wouldn't agree with. That is their right, but the fact is that it is approaching that problem in a threefold way—I think they have representatives of management, labor, and government who work together to try and resolve these differences in international problems.

I want to make it clear for the record that, as far as I am concerned, this committee is entirely in favor of and approves the approach of the ILO to these serious questions.

Mr. COHEN. I would only like to say in reference to what you said, Senator, this one illustration that I have just picked out is only one of the countless misstatements about our relationship to the ILO that is being circulated. I have just picked out one to illustrate to you, because it was rather specific, but here is a whole document [exhibiting "Labor's Program To Socialize Medicine Internationally, Medical Economics, 1945"] that is going around which was reprinted in thousands of copies, reprinted, circulated to the medical profession, to the public generally, which traces the whole relationship with the ILO as if it were something illegal, subversive, irresponsible, and in which our participation was unauthorized and unwarranted.

Now, if you had the time—I think you have only scratched the surface of these misrepresentations—if you had the time and you had the willingness, I would say go into these other matters. We would be glad to present you with all the information, but I wouldn't want to leave you with the idea from what I said about the ILO that that was the only item upon which there was misinformation circulated.

Senator MURRAY. Mr. Cohen, it would be almost impossible, would it not, to wipe out all this propaganda that has been put out over the country in connection with these matters that we are considering?

Mr. COHEN. Well, it has certainly done irreparable damage, Senator. I don't know how you can ever repair that.

Senator MURRAY. We pick up pamphlets and statements every day filled with distortions and falsehoods and misrepresentations with reference to this proposed legislation being circulated all over the country, being distributed from the drug stores in the country, and it seems to me that it is going to be very difficult for us to get before the people a correct and honest understanding when you consider that millions and millions of dollars are being devoted to this kind of propaganda. Expensive circulars are being put out every day almost.

Senator SMITH. Who, do you suggest, Senator, are spending the million dollars?

Senator MURRAY. Well, different propaganda organizations. I understand that the physicians' committee is spending millions of dollars and taking up collections from the big drug houses of the country and using that money for the purpose of misrepresenting the facts to the people of the country. I don't think there is any dispute about that.

They have registered, I understand, as lobbyists in connection with this matter and are taking up collections all over the country.

Senator SMITH. I am not familiar with that.

Senator MURRAY. So that it seemed to me that where people who oppose legislation in this country have access to such sources of wealth, that it is almost impossible to combat them in connection with this legislation that we are trying to present to the American people.

Senator SMITH. The committee will stand in recess until 2 o'clock. I want to thank Mr. Cohen and Mr. Falk for their testimony.

(The committee then, at 12:30 p. m., recessed to reconvene at 2 p. m. of the same day.)

AFTER RECESS

(The subcommittee convened at 2 p. m., pursuant to recess.)

Senator SMITH. The meeting please come to order.

On June 25, last, Dr. Maurice H. Friedman, of Washington, D. C., testified in these hearings. His testimony appears on page 640 of the hearings of that date and subsequent dates, and on page 685 appears a letter that Senator Murray asked to be inserted at the close of Dr. Friedman's testimony, a letter from Senator Murray to Mr. Watson Miller, the Federal Security Administrator. Following that, Senator Murray requested an analysis of Dr. Friedman's testimony and a statement from the Federal Security Administrator with regard thereto.

That statement of the Federal Security Administrator appears on pages 685 and following of the testimony. I received a letter from Dr. Friedman a short while ago requesting that he be allowed to appear and give some further testimony with regard to the criticism made of his previous testimony of June 25.

We invited Dr. Friedman to come here and gave him the courtesy of a further hearing in order that we may settle some of the issues, if we can, that are presented by his testimony and the analysis by the Federal Security Administrator.

So, with that statement, Dr. Friedman, if you will go on in your own way and give us your statement as you wish to have it appear in the record.

Senator Donnell. Mr. Chairman, might I ask permission to request the doctor to state just a little more fully than he did in his initial testimony some of the professional experiences he has had in that it will bear upon his qualifications here to give testimony on these matters?

Please, Doctor, don't be too modest. Go right ahead, if you will, sir, and just give us the facts that you think would have a bearing on your qualifications.

FURTHER STATEMENT OF DR. MAURICE H. FRIEDMAN, WASHINGTON, D. C.

Dr. Friedman. If the committee will grant me the privilege, I shall not give them all the facts, but only those pertaining to the direct matters at hand.

I am, in the first place, a practicing physician, being duly licensed to practice in this district. I have been recognized by the American Board of Internal Medicine as a specialist in internal medicine. I am a consulting physician in internal medicine to the United States Veterans' Administration, having consulting service at Mount Alto Hospital. I have been accepted by the Naval Retirement Board as a specialist in many hearings regarding retirement of naval officers. I have had faculty positions, including one for 10 years at the University of Pennsylvania Medical School at full-time appointment, and I have had 15 or 20 years' experience in research and investigation in the medical sciences, which I prefer not to detail here at the moment.

I think that covers the matter sufficiently, Senator, if you please.

Senator Donnell. Thank you.

Dr. Friedman. There are two matters I should like to call to the attention of the committee before proceeding with my statement of the day.

I notice that inadvertently the summary of my previous testimony was completely omitted from the printed version of the Senate publication. I am sure that was an error, that it was not intentional, but it so happens that in my zeal to make it easy for the committee to refer to my summary and the body of my statement, I prepared the summary separately and handed the both parts in, so that the Senators could easily look at my summary and then the text. Unfortunately, only the body of my statement was included, and the important points of the summary were completely omitted.

Senator Donnell. Mr. Chairman, I move you at this point that there be inserted in this record the summary to which the doctor refers.

Senator Murray. Yes; I think we ought to have it. I remember there was a summary, but I had nothing to do, of course, with reference to the preparation of the transcript, and I imagine that they must have overlooked it.

Dr. Friedman. I think it is my own fault for putting the two things separately. I take responsibility for that, but it was an unfortunate error.

Senator SMITH. We will have it inserted at this point in the record. (Dr. Friedman's summary is as follows:)

SUMMARY BY DR. MAURICE H. FRIEDMAN

SUMMARY OF DISCUSSION ON SELECTIVE SERVICE DATA

1. The male population examined by the Selective Service System was not truly representative of the young adult male population of the United States.

2. The high physical standards set by the armed forces disqualified many men who were successfully carrying out their tasks in civilian life and who had no reason to seek medical attention.

3. Fully two-thirds of the rejections of selective service were for causes which are beyond the powers of the medical profession to correct or prevent, regardless of the amount of medical service available and regardless of the cost of medical care.

4. Not more than 20 percent of the rejections were for causes which could conceivably have been influenced by medical care, and even this figure was reached only after making the assumptions that (*a*) every person with such defect would have consulted a physician; (*b*) that in every instance the physician would have recommended corrective measures, including major surgery; (*c*) that in every instance the patient would have accepted these recommendations, and (*d*) that the measures taken would have been 100 percent effective in every instance.

5. The high rejection rates for Negroes are accounted for by the high incidence of venereal disease, mental deficiency, and mental disease. These conditions accounted for over 60 percent of all rejections of Negro registrants.

6. As amply shown by the experience of the armed services, no amount of medical care freely available without cost has much influence on these conditions.

7. With the exception of cardiovascular disease, venereal diseases, and educational deficiency, the incidence of every other disease and defect was lower in Negroes than in the white registrants.

8. The high rejection rates for registrants from the Southern States are accounted for by the high percentage of Negroes in the population of these States, and the outstandingly high rejection rates for syphilis and educational deficiency among the white registrants from these States.

9. The futility of attempting to use the selective-service data for any discussion of medical care is placed in bold relief by the data on tuberculosis. All surveys of the Selective Service System confirm the higher incidence of tuberculosis in the white population. If we were to use the same kind of logic as that employed by the proponents of compulsory health insurance, we might conclude that with respect to tuberculosis the Negro was receiving better care than the white man. But the death rate for tuberculosis is much higher for Negroes than for the white man.

10. Those defects for which selective-service registrants were rejected have very little significance with respect to the general health of our people. The selective-service statistics have no place whatsoever in any honest discussion of deficiencies in our medical services.

SUMMARY OF MEDICAL FACILITIES IN RURAL AREAS

1. The people of rural communities use hospital facilities less frequently than people in similar-income groups in the largest cities.

2. The cause of this difference has not been disclosed by any study cited to date.

3. Almost 80 percent of the people in our rural population live within reasonable access to hospital facilities.

4. A lack of hospital beds does not seem to explain this difference inasmuch as the people in rural communities do not fully use the beds to which they have access.

5. In rural communities a greater percentage of "illnesses" are unattended than is the case in the large cities. The reason for this difference has not been revealed.

6. Despite this larger percent of unattended illness, the available data show that persons in rural communities employ the services of a physician just about as frequently as do persons of comparable income in the largest cities. People living in cities of 5,000 to 100,000 employ physicians' services much more frequently.

7. With respect to health examinations and immunizations the rural population is significantly better off than comparable income groups in the cities.

SUMMARY OF THE ECONOMIC BARRIER TO MEDICAL CARE

1. According to a survey conducted by I. S. Falk and his coworkers, the incidence of illness is lowest in the low-income families and rises with rising income to be highest in families with incomes over $10,000.

2. One factor contributing to this situation is the higher proportion of older persons in high-income families. In the $10,000 income class the percentage of persons over 45 years of age is over twice that in the three lowest income groups.

3. About one-third of all "illnesses" in the lowest income group are unattended, but over 50 percent of all recorded "illnesses" are ambulatory and almost one-half are not disabling (that is, do not interfere with work or usual activities).

4. Under the present system of medical and dental care—

(*a*) The volume of dental services rendered increases progressively with rising income. There is a definite correlation between income and the volume of dental services.

(*b*) The volume of services rendered by private physicians rises somewhat with increasing income, but the increment is slight when compared with that for dental services. Persons in families with incomes of $2,000 to $3,000 received only 19 percent more consultations than did persons in families with incomes less than $1,200.

(*c*) Up to family income of $5,000 per year there is no correlation between income and volumes of services with respect to hospital care and immunizations.

5. The proponents of compulsory health insurance have grossly underestimated the significance of the services donated by private physicians to the low-income groups and the volume of free and low-cost hospital care. Free hospital care was given to 52 percent of all hospital cases in families with less than $1,200 income.

6. Up to the present time there has been no survey or analysis which has determined how many people in this country have been deprived of medical care because of an economic barrier.

7. The most frequently cited estimate of the cost of medical care is that of the Committee on the Cost of Medical Care. The figure given is $30 per capita, or about $100 per family.

(*a*) This estimate includes many items already paid for by taxation or by philanthropy and for which the private individual need not pay again, either in the form of insurance or any other form.

(*b*) This estimate is for the cost of services only and does not include any charge for administrative costs which would have to be added for the operation of any insurance plan. Nor does it take cognizance of the change in price levels from 1929 to the present time.

8. Any insurance plan, whether privately or governmentally operated, will increase the cost of medical care per person to the extent of the charges for administrative costs.

9. The net money income of a family is not a fair criterion of ability to pay for medical care . Even in urban communities a considerable portion of the total income of low-income families is in the form of goods or services received in kind. In farm families the portion of the total income received in kind accounts for 30 to 60 percent of the total income.

10. Based on the pattern of family expenditures for 1935, farm families with total (not cash) incomes of $1,000 or more could have paid a premium of $100 for health insurance by diverting 30 percent or less of their optional expenditures (nonessential use of automobiles, tobacco, gifts, etc.) to supplement the sums actually spent for medical care.

11. In any year there are bound to be some families which cannot afford to pay their full share of the costs of medical care. Provision of medical care for such families is not a problem of insurance—it is not a problem of spreading the unpredictable costs of the changes of illness over a self-supporting population. Provision of care for such families involves subsidy or charity.

12. No discussion which confuses health insurance and subsidy is likely to provide reliable guides for a wise public policy.

SUMMARY

1. The plan for national compulsory health insurance carries distinct threats to the freedom not only of the physicians of this country, but to the freedom of every individual.

2. In return for a premium equal to about 4 percent of each individual's annual earnings, the provisions of S. 1320 offer no specific contract of services. At any time the services rendered can be reduced by a ruling of the Federal Security Administrator.

3. S. 1320 does not offer complete medical service on a prepayment basis.

4. There are now in operation a number of successful, voluntary, prepaid insurance plans.

5. From the operating experience of these plans we cannot help but gain valuable experience to guide us toward a sound policy regarding medical care.

6. It is evident that expansion of medical facilities alone will not suffice to meet our problems. We must determine in each area the relative need for education, housing and plumbing, sanitation and public health measures, improved highways, or additional medical facilities. The people must be taught how to use these facilities to the best advantage.

7. The problems confronting this Nation cannot be solved by the establishment of a fully staffed hospital or group clinic at every cross road.

8. The medical profession cannot shield the entire population from the consequences of illiteracy, overcrowding, undernutrition, and the widespread neglect of personal and public hygiene.

9. The health of this Nation is not in such desperate state that we must rush to surrender complete control of our medical care into the hands of an all-powerful Federal agency.

Dr. Friedman. Now before commencing my specific comments on this controversial matter, I should like the indulgence of the committee to discuss with them, as we might with friends, a doctor's viewpoint on how to evaluate the health of a community.

I have put this into my testimony at a later point, so that it will be subject to all the rights of cross-examination and interrogation later on, but it was so important that I thought I would like first to discuss this with you, leaving out all controversial matters, and merely try to tell you as best and as simply as a physician can what are the factors in trying to evaluate the health of a community or nation or any other community. If I may have that privilege for about 5 minutes, I will then proceed with the rest of my testimony.

Senator Smith. Go ahead in your own way, Doctor. We want to hear the story as you want to present it.

Dr. Friedman. I am quite certain there are some segments of our community that are not receiving the very best of medical care. I am quite certain that if we reviewed all the statistics, we would see that there are some places where medical care is not what it should be, but I don't think for a moment that we can get a clear picture of the health of the community merely by recording defects that exist for the following reason. Particularly, of course, I am referring to such tabulation as the selective-service data.

I am not reflecting on the accuracy of that data. I am just trying to reflect on how we might interpret those data. In the first place, a great many of the defects discovered and listed have very little significance to health. That is not only my opinion, but it was repeatedly pointed out in the official bulletins of the selective service statistics.

Over one-half of the defects listed are structural abnormalities rather than diseases. They might be minor things. A man might have the tip of one finger knocked off or something of that sort. Of the remainder of all these defects, a significant number are related to education rather than to medicine or to health.

Considering only the structural abnormalities—it is a bit ironical that rather than being the result of a lack of medical care—many of these defects are the direct result of medical care. For example, amputations are frequently done as a lifesaving measure or for surgical or medical purposes. Amputations are recognized method of treatment of some traumatic injuries. Amputations, therefore, are one kind of defect which is a direct result of medical care, not the absence of medical care. Surgical perforations of the middle ear are another example of a medical care which produces a defect for the relief of a disease. We have many other examples.

The very existence of these defects, therefore, is the evidence of previous medical care. Not only that, but the very existence of some defects is an evidence of our good health, rather than the contrary, strange as that may sound.

The fact that diabetics live long enough to be registered by a draft board is only due to our medical services. They are then recorded as a defect. The fact that they do live long enough is only due to the wonders of modern medical care and by the grace of Best, Banting, and Collip. I should like to say here that Bert Collip has never received proper credit for his work with insulin.

Every child with rheumatic fever nursed into adult life by skillful medical care will live with a defect. Every invalided infant who survives the tetralogy of Fallot by skillful surgery will increase the recorded number of rejectees. We might ask ourselves: Is a corpse healthier than a rejectee with diabetes?

In order to evaluate the health of a community, one must consider, among other things, the crude death rate, the death rates for specific diseases, the age composition of our entire population, the morbidity rate for various diseases and for childbirth, the birth rate, and the life expectancy. These are the things we must consider.

Even when we have carefully and satisfactorily evaluated the health status of our community or one segment of our population, we cannot draw any inferences regarding medical care or the volume of medical care services without allowing for many other factors.

Medical care is but one of the factors which determine the health of a community. I gave some evidence of these other factors in my original testimony by reference to the statistical work of Dr. Hyde in Boston.

I should now in closing this section give a few more illustrative examples. In the Philippines and in China our troops had just as many doctors as the Army had any place in the world. Nevertheless, at a time when poliomyelitis was not existing in the native children and was not epidemic in the adults, our soldiers were coming down with this disease by the dozens. Was this because our soldiers did not have as good medical care as the surrounding population? The official explanation is something else.

It is believed that while our soldiers had built up considerable group immunity to our own United States strain of poliomyelitis, they had built up no immunity to these foreign strains, because they had never been previously exposed to them.

This illustrates one of many examples of the relation between the individuals or the host and the invading organism or the environment.

Another factor, and I shall not labor this point, is purely geographic. It is well illustrated by the distribution of rheumatic heart disease in this country. The incidence of rheumatic heart disease in Louisiana is much lower than it is in New England. We can't say, because of that, that the medical care in Louisiana is better than in

New England. We can't say anything at all about that. It is indeed true that the child of a poor Negro farmer in Louisiana has less chance of getting rheumatic heart disease than the son of a wealthy Boston family.

There are many other examples, but these will suffice. In plain words, one cannot say that the medical care in Wales is poorer than that in New Zealand merely on the basis of certain differentials in death rates or morbidity rates. These rates will reflect medical care only if other equally important factors are the same. That is the point of view I would like to get before you. I don't think there is any controversy about that. That point of view will be backed up to the hilt by every scholar in or out of Government, and I think it is important that we focus on that, that we realize that because we have a diabetic recorded in the draft rejection figures, that is not necessarily—in fact, it is indeed not a sign of ill health.

What shall we do? Let them die off? We would have much better-looking figures if we did that. But that is not the function of the medical profession, and with your permission, I shall proceed now with the rest of my testimony.

Are there any questions now that you gentlemen would like to ask about this?

Senator SMITH. Well, the conclusion from that statement is that the percentage of rejects isn't a sound yardstick in determining whether or not they have had adequate medical care.

Dr. FRIEDMAN. It is no yardstick at all, as I have tried to show. That is the point.

Now to proceed to those points at which I would welcome criticism and further examination.

The members of the Federal Security Administration have had occasion to differ with me on several interpretative points. They have questioned my medical judgment, my familiarity with statistical procedures. The lay members of the Federal Security Administration have even undertaken to lecture me about the treatment of diseases in my own special field. That is their privilege, but significantly, they have not challenged the propriety or the verity of any of the data I have submitted, and you will please note that in the rebuttal.

They have not said that any of the data I have submitted is false, that it has been misquoted, or that it is distorted. They can say that I didn't quote all of it, and I did not; I did not have the time to do that, but they have not said that my quotations are incorrect.

This, gentlemen, is a one-man job. I have no staff. I have no technical aids. I even did my own typing. Because of the size of this job, I would be very much surprised if I didn't make some mistakes. In fact, I am sure that if competent critics would look it over, they might find a few; I don't think they are significant, but I am sure there are some in there.

There are competent men in the Government service, impartial scholars, in the Bureau of Vital Statistics, Public Health Service and other departments whose opinions I would welcome, whose criticisms I would highly respect, because I think they could come to this controversy with an impartial mind.

Indeed, a few weeks ago, I had a discussion with a member of the Public Health Service who is frankly for compulsory health insurance. We had a very amicable lunch together, aired our views, but we had no difficulty on agreeing as to the facts, none whatsoever. Our differences were a matter of public policy. I regret to say that I cannot include the members of the Federal Security Administration in this category of impartial critics. They have been and are vigorous advocates and special pleaders for specific legislation which is designed to multiply their own powers and expand their own influence.

I do not attribute to them any malicious motives, but it is a natural bias. These things are designed to increase the power of the Federal Security Administration. They cannot be held up as impartial judges as could these scholars about whom I am talking.

I should like to call your attention to the fact that, despite the fact that many physicians have testified in favor of S. 1320, and I should make mention here that one of them, John Peters, is an unquestionable scholar and gentlemen; I would certainly respect his opinion. I would have no hesitancy about submitting this controversy to him and say, "Dr. Peters, let's have your opinion on it." But despite the fact that many of these physicians have testified in favor of S. 1320, not a single physician has come forward to testify or support the claim of the Federal Security Administration that one-half to two-thirds of rejections of the draft statistics could have been avoided by timely medical care. That is glaring omission from their testimony. Not a single one.

They have submitted an estimate by Dr. Leonard Rowntree, which I will refer to later, but this estimate does not substantiate their claim that 50 or 60 or 70 percent of those rejections could have been avoided. Dr. Rowntree says, in his opinion, 15 percent of the rejections were for causes which were remediable, and if you can recall, I myself bent over backward and said I thought we might say 18 or 20 percent of the rejections could have been avoided by medical care.

The Federal Security Administration states that my appraisal of the significance of the selective-service data is in conflict "with the opinion of the medical men in charge of that program." They offer nothing to substantiate that statement except the opinion of Dr. Leonard Rowntree, who was an officer at one time of the Selective Service System, but he does not represent all of them and he is no longer with them.

I have personally had many conversations with the officers of the Selective Service System, and if there is any disagreement of opinion between us, I have not become aware of it up to the present time. As a matter of fact, even Dr. Leonard Rowntree, in discussing these statistics, cautioned the committee in your own records about some of the matters I have brought up in my original testimony and to which I shall refer later.

Time and time again the official bulletins of the selective service committee have issued these same warnings. Those are not matters which are hidden, but it is significant that the Federal Security Administration has not emphasized these warnings.

I should like to take this opportunity to pay my respects to the members of the Selective Service System who are responsible for the collection of that vast body of data and for the publications in which these data are discussed. Their presentations have been clear and scholarly. The limitations of that data have been set forth so forthrightly in such prominent places that no one, with or without special training, has any excuse for misinterpreting the data. If the presentations of the members of the Federal Security Administration had been of the same character, we should not now be engaged in this controversy.

The rebuttal of the Federal Security Administration not only reflects errors contained in the more detailed sections, but compounds error upon error by introducing into the summary some statements which are unsupported by their own detailed discussions. They state:

> Data available from Selective Service System undeniably reflect the greater prevalence of defects among rural and Negro groups in comparison with the urban population.

I am quoting now from hearings on S. 1320 in the volume before you, page 687.

Nowhere in their extensive discussion do members of the Federal Security Administration submit one iota of evidence to support this statement. Up to the present moment, the members of the Selective Service System have not published any data on rural and urban defects. As a matter of fact, if such data are in existince, the present officials of the Selective Service System are unaware of it. They don't know the existence of such data.

I say that on the basis of my repeated conversations with them, and, as a matter of fact, I have recently undertaken to correlate such data, as I will be glad to explain in detail—I have the data in my brief case, but I have been only able to complete three States—Iowa, Indiana, and Illinois—and that is a terrific job. The members of the selective-service committee have asked my permission to use that data and to quote that data, and I have just given them permission. What use they are going to make of it I don't know, but so far as I know, the only data in existence of urban and rural defects was done by myself a few weeks ago; it has not been published, and was done only through the courtesy of the Selective Service System, where I could examine the raw data as they have it, county by county.

So when the FSA says there is data to support this, I don't know whether they have it or not, but if they have it, the Selective Service System people don't have it. They didn't know anything about it until I gave them this data myself recently.

There are, of course, data on defects on Negro and white registrants. I have frequently cited these in my original testimony. The statement of the Federal Security Administration attributing a higher defect rate to the Negroes is altogether false, as is easily demonstrated by the reference to all selective-service publications without exception. As a matter of record, in the first 10 pages of their rebuttal, there are seven statements, including the one just cited above, which are flatly contrary to fact, as can be easily demonstrated by reference either to my original testimony or to readily obtainable publications such as those of the Selective Service System.

In the following detailed discussion, I propose to cite these errors to substantiate every statement I have made, and I shall, in doing so, refer by page and paragraph to this publication as we now have it here.

We now come to the discussion of the draft rejection figures as discussed in this volume on page 691. I admit that Dr. Rowntree expressed some differences in his appraisal of those statistics, but he did not cite any evidence which was against what I have already cited, and I should right here like to cite a reference from the official publication of the Selective Service System. It is from Selective Service System Medical Statistics Bulletin No. 1, page 10, footnote No. 2:

> There seems to be little doubt but that most of the registrants being classed as available for limited military service and a substantial portion of the registrants being classed as disqualified for any military service in the United States Army possess health conditions which would be acceptable for military duty in any army in continental Europe.

Here is another quote from the same publication, page 10, paragraph 3:

> In addition to the nondisqualifying defects, a large proportion of the disqualifying defects are minor insofar as health conditions are concerned. The loss of an index and middle finger, the loss of a great toe, or the fact that a registrant is less than 60 inches in height is sufficient cause for rejection, but such conditions do not indicate that the registrant is in poor health.

This is from the official publication of the Selective Service System. Gentlemen, that is the point I have been trying to make all through my original testimony:

Selective Service System Medical Statistics Bulletin No. 2, page 3:

> Failure to meet the relatively strict standards then in force did not necessarily mean that the rejected man was seriously handicapped for a useful role in civilian life or for many kinds of noncombatant service in the armed forces.

I say again that the Federal Security Administration persist in their statement that 50 to 60 or 70 percent, whatever they say, of these rejections were preventable by medical care, and I say again not a single physician has come forward to corroborate that claim. Dr. Leonard Rowntree, as I have just said, cited 15 percent. Therefore, their estimate must be regarded as one derived from an analysis of technical medical problems by lay persons altogether incompetent for such a task.

We now come to the section headed "Significance of selective-service sample," which you will find in your volume on page 692. The first statement made by FSA under this heading is contrary to fact. They can cite no statement of mine which charges the Selective Service System with failure to point out limitations of this population sample.

I have cited, in the words of the Selective Service, their own qualifications, and I should like to quote from them again. I have said, and I say repeatedly, that some of the proponents of compulsory health insurance did not warn the committee of these limitations, and that has been established by the record. I did never charge the Selective Service System with that. So when the FSA claims that I have charged the Selective Service System with failure to give these warnings, that statement is contrary to fact.

I have quoted this, and I will quote it again. This you will see in my text on page 657. There is a bibliographic reference 5, page 3, and I shall quote:

> However, several pertinent factors have often been neglected in public discussions of these rejection rates. (1) A large number of physically fit registrants chose to enlist in the armed forces without awaiting induction through the Selective Service System. If they had entered the armed forces through selective service, the records would show larger numbers of inductions, the same number of rejections, and lower rejection rates.

I stated that explicitly in my original testimony. So far as I am aware, the members of the Selective Service System cannot properly be classed as proponents of compulsory health insurance. My statements could not possibly have referred to them. Quite properly to be classed in this category, however, are those members of the Federal Security Administration who have publicly and vigorously advocated this course of action, and so they are, therefore, properly classed as advocates of compulsory health insurance.

It is these men, so far as I am aware, who have not cautioned the committee against the use of these statistics in such clear language as the Selective Service System has cautioned the committee.

Now we come to factors governing rejection rates. That is on page 692. The Federal Security Administration states that the publications cited by me emphasize the prevalence of defects and not the proportion of men rejected. This statement is flatly contrary to fact, as can be readily seen by anyone who will inspect the selective-service bulletins cited in my bibliography.

I should now like to paraphrase a thesis with which the Federal Security Administration has approached the problems. I hope I am not doing them an injustice. They have really never so succinctly or definitely expressed it, but I think this is about the procedure: (1) Diseases or defects for which there are remediable therapeutic procedures should not exist. (2) Any existing cases of such diseases or defects are to be regarded as evidence of medical neglect. (3) The extent to which such diseases or defects exist is a measure of the inadequacy of medical care, due either to the maldistribution of medical facilities or to an economic barrier.

That is essentially the thesis. I hope I am not doing them an injustice. Despite our wishes in the matter, we must face the hard facts of life.

I don't think the armed forces really designed this in the following way, but they really conducted a 4- or 5-year experiment on over 10,000,000 men in which the cost of medical care was not a factor. The medical care was free. No one had to pay for it. This was true of all diseases and specifically of the venereal diseases, which I should now like to dwell upon, because so much has been made of it.

If I may, I would like to cite from memory. I am losing myself here a little bit to tell you what we did for venereal disease in the Army. Contrary to the last war, men were not punished for having venereal disease. They lost no pay. They didn't have to pay for medical service. That wasn't all of it. That wasn't all of it.

We had in the Army venereal-disease officers who made it their full-time duty to indoctrinate and educate our soldiers about venereal disease. We pleaded with the men to come in and use our facilities. We not only gave it to them, but we begged them to use it. We not only begged them to use our medical facilities, we also provided free to the enlisted men but not to the officers, and there was gross discrimination in the Army in that respect, prophylactic devices at no cost and taught the men how to use them and begged them to use them. They were available in every day room in the Army, as any GI can tell you.

Not only that, we established in every town of any size what were called prophylactic stations which were readily available and open all night. Not only that, I suffered the indignity, along with all other medical officers, of having to get up at 2 or 3 o'clock in the morning to pull surprise inspections on these troops for men who would go out and get venereal disease and not report it.

That wasn't all. When we found an outfit that was particularly bad, we confined them to the base without privileges of going to town or any place else. At one time, gentlemen, we even confined one squadron in barbed wire. They couldn't even visit the PX on the base.

Did that wipe out venereal disease? No. Venereal disease was rampant in every military installation in the United States. New cases occurred among those soldiers behind barbed-wire confinements, the details of which I choose not to repeat here now.

The point was, we not only provided free medical care; we provided everything we could for the soldiers. You couldn't duplicate those conditions in civilian life. Not only was there venereal disease rampant in the Army, but this is the tip-off. The ratio of venereal disease in the colored man as opposed to the white man was precisely the same in the Army, with all the care, with all these precautions, as it is in civilian life, and I have in my pocket telephone recorded data from the War Department.

So, when we find venereal disease in our civilian communities, we cannot charge that up against a lack of medical care or the cost of medical care or anything like it. That is why, gentlemen, I said it, and I know it sounds strange, but the problem of venereal disease is not a medical problem. It is a problem of social and moral discipline. Even in the Army, it wasn't the doctors who had the power to issue those commands. We didn't string the barbed wire. We were merely technical advisers, and I think there is full justification for my statement when I say no amount of free medical care will abolish venereal disease. There is an experiment—10,000,000 men, 4 years, and you can't ignore that.

Are there any questions so far, gentlemen?

On page 693, the Federal Security Administration makes a statement that environment is a very important factor in the development of mental deficiencies. I wholeheartedly agree with that. I insist upon it. We must remember that mental deficiency was not clearly differentiated in the Army from lack of educational opportunity. In fact, those two things were classed together, and I shall quote here again from Selective Service Bulletin No. 3, page 26:

> Mental deficiency and educational deficiency are generally grouped together for purposes of discussion. The line of demarcation between the two groups has never been clearly defined.

They go on to point out, in trying to combat my testimony, that the classification wasn't proper.

I am quoting here the official publication of the selective service bulletin, and they say again:

> Only a small portion of the group was comprised of morons, imbeciles, and idiots.

The others were just a vast conglomerate of men, many of whom did not have proper educational facilities, and they were classed either as mentally deficient or educationally deficient.

If the committee is getting a bit tired, I could tell them a very amusing incident about some of this stuff, or I shall go on, as the committee desires. What is your wish, gentlemen?

I can go on with my testimony. I am trying to make you a little more comfortable. [Laughter.]

Senator MURRAY. That is all right with me. I am perfectly willing to stay here. [Laughter.]

Senator SMITH. Do as you prefer.

Dr. FRIEDMAN. Well, I think this is pretty serious. I would like to tell you this story; it will take a moment. We will stop here.

Just to show you how coincidents happen I was fooling around in the library in 1938, and I came across three articles which were funnier than anything I ever read in a scientific library.

The first one was in the Nederlandische Tidschrift in 1938. It was entitled "Physiological Observations on an Oboe Player." The article was in Dutch; and although I can't read Dutch, it was funny even then. The next article was an exposé of an error made by the late great Harvey Cushing. He had erroneously listed the height of one of his acromegalic giants as being 8 foot 4 instead of 7 foot 4. The article goes on at great length to tell how this error happened; but it was essentially due to the fact that on the day this man died they did not have a yardstick handy, and the measurements were made with a 1-foot ruler. The error was introduced by the fact that Dr. Cushing's assistant miscounted the number of times he put down and picked up that 1-foot ruler.

Now, the third case—these things run in threes—concerns the case of a Czechoslovakian greenhouse worker—and this is important; it is not so funny—who was afraid of doctors. He was so afraid of doctors that when something hurt him, like his finger, he would just chop it off, which he did. There is another defect for the draft rejection figures. [Laughter.] I hope my technical language will not offend anyone, but he had a pain in his testicles once, and he chopped that off, one of them. Now the thing that brought him to the hospital—and this article was published by Chester Guy in the Journal of the American Medical Association of 1938; it makes fascinating reading—that man had a bellyache once, and this was in the days before sulfa, and they picked him up in this bloody mess in the street and took him to Cook County Hospital in Chicago and patched him up; and by the grace of something or other, he lived.

But before discharging this man back to civilian life, they thought maybe they ought to have the psychiatrist see him, because maybe he wasn't quite right mentally; and this is what I would like to emphasize—I can't remember all the detailed discussions:

One man, the first man that wrote the opinion, said:

> This is a very high-grade moron, as good as any, and he is not admissible to the psychopathic division.

[Laughter.]

The second quotation I can't remember. The third quotation comes from Harry Singer, now deceased—and that is interesting, too, because of all the male members of that generation, not a single one lived to be 45 years of age; they all died from high blood pressure, and he is deceased, too—but before he died, he issued this perfect gem of a discussion. He said:

> This man is probably mentally deficient by our standards but not by his. He is not admissible to the psychopathic division.

[Laughter.]

I hope this has been worth your while, gentlemen.

Admitting that many of these cases of mentally and educationally deficient are the result of environment, the physicians are not in control of environment. We don't form the environment. We don't influence it except by our modest efforts in medical care. Where does the FSA present testimony by experts, qualified experts, that the medical profession is responsible for the appearances of these mental defects? It is one thing to charge it by a group of lay people; it is something else to have some qualified man substantiate it.

I could go into the question of cretinism, which they bring in. They are just tilting at windmills when they bring that into the picture. Statistically it is unimportant; I wouldn't even discuss it unless you wish. Actually, cretinism can be controlled and is controlled by dropping a little iodine in the salt, which we are doing now. We don't need any medical legislation for changing the entire social order of this country to control cretinism; and I might tell you on the side that goiters, which are related to cretinism, were present not only in the people of the Great Lakes region, so that the ladies had to wear high-necked shirtwaist bands to hide their big necks, but all the dogs, fish, and frogs and snakes around Chicago had goiters, too; and the medical care available to the snakes and the frogs and the fish has not increased one iota in Chicago; and we don't have goiter any more out there, by the simple expedient of dropping a little amount of cheap iodine in the salt. So I wouldn't even discuss that.

Now we come to the point of conditions not preventable and not remediable, and so forth. I should like to call your attention right now to the great distinction which the armed forces make between men who are already in the service and those who are about to be brought in. For example, gentlemen, for 4 years I sat on boards that were handling these problems every day in the week, and toward the last part of the war we had what were called profile boards.

We had groups of specialists meeting together every day to see whether not only could the man leave the hospital, but was he fit to go back to service or should he go back to civilian life. So, essentially, we were doing the same work that the induction stations were doing.

Peptic ulcers, for example, will not be accepted by the Army. That is cause for rejection. They wouldn't take them. But once a man got into the Army, not only if he had a peptic ulcer but even if he had perforation or hemorrhages, we would doctor him up and send him back to duty. So when the FSA tells me that 70 percent of neuropsychiatric patients were returned to duty that doesn't mean anything. Of course, they were returned to duty, but it is one thing to return to duty an individual who has succumbed to these unusual strains of war and quite another to try to rehabilitate an individual who had been unable to adjust himself to the ordinary demands of civilian life. So that data is not pertinent. I admit that we returned a lot of men to duty. That has nothing to do with the point whatsoever.

We next come to the statement by the FSA that 8 percent of mental diseases can be cured. They say that on page 694, and also show that in tables B and C. They also state that only a small percent of the 17 or 18 percent of IV–F's rejected for mental disease had serious mental disorders.

Dr. Felix, whose letter is submitted on page 721, says that hardly more than 1 in 10 were rejected for grave mental or personality disorders. It is quite true that of all rejections from mental diseases, only about 11 percent—Dr. Felix is absolutely right in stating those facts were for conditions specifically labeled as such "grave mental or personality disorders." Yet another 2 percent were labeled "major abnormalities of mood, 27.3 percent psychopathic personality," and, gentlemen, I am quoting these figures from Selective Service System Medical Bulletin No. 3, table 5, page 122, "approximately 6 percent chronic drunkenness or drug addiction."

Now, for those who are unfamiliar with these technical terms, except for chronic drunkenness, and so forth [laughter]——

Senator DONNELL. I think the committee is acquainted with that term.

Dr. FRIEDMAN. I should like to quote the War Department definition of some of the kinds of psychopathic personality which we are told by the FSA rebuttal are not serious mental diseases:

> In this ill-defined, more or less heterogeneous group are placed those individuals who, although not suffering from a congenital defect in the intellectual sphere, do manifest a definite defect in their ability to profit by experience. They are unable to respond in an adult social manner to the demands of honesty, truthfulness, decency, and consideration of their fellow associates. They are oftentimes in conflict with the law. Among this general group are three main types—I am still quoting War Department—I have got it right here—MR 1–9:
>
> (1) Psychopathic personality with pathologic sexuality. This may include many homosexuals and cases of sexual perversion, etc.
>
> (2) Psychopathic personality with emotional instability.
>
> (3) Psychopathic personality with asocial and amoral trends. This includes the pathological liars, petty offenders, swindlers, kleptomaniacs, pyromaniacs, etc.

Gentlemen, it is your privilege to consider these as insignificant mental aberrations of normal behavior, but the War Department did not consider them. To that extent, I must seriously disagree with Dr. Felix. On the other hand, there was a little exaggeration in the other direction. About one-half of all rejections for mental diseases are labeled psychoneurosis, and here I cite medical statistics, Selective Service System Bulletin No. 3, table 5 again, page 122:

> Many of these, of course, wouldn't be considered mental diseases at all. On the contrary, by usual standards, they would be regarded as normal men—

or if you want to use Harry Singer's words—

> even by their standards.

Col. William Menninger, psychiatric consultant in the Army, before this very committee emphasized that point, and that should be registered. I shall quote. He said:

> It has been no surprise to psychiatrists that this segment of the population has been uncovered—

meaning these psychoneurotics—

> and is no special cause for alarm as to the mental health of the Nation. It concerns—

please note—

> our family life and our educational system. It is intimately linked with the prevailing attitude of the public toward their specific service in the Army. To many men, the security of their homes and their friends and their jobs far outweighs their belief in their importance for, and their need by, the armed forces.

> The rejection of this group of men for acceptance to the Army has been widely misunderstood and misinterpreted.

Please note—

> The Army, like a football team, needs the best. The fact that a man may be a regular worker, a community asset, is no indication that he can fit into the Army or be an asset to the Army. Many men can hold a civilian job with efficiency who would be unable to fit into the regimentation and discipline of the Army.

Please note that Colonel Menninger emphasizes the role of the family, our educational system, and the "prevailing attitude of the public" in determining the mental reactions of this group of men. Indeed, in a very illustrative article in the lay press—I will be able to give that to the committee; I have it here, I hope—Colonel Meninger went on to discuss this at great length. Yes; I have it here. I should like to have the committee, if they please, read this at their leisure. I have finished with it.

In the Atlantic Monthly of January 1948 he called attention of the lay public to the fact that the personality of the individual is formed during childhood and early adolescence by the reactions of the environment on the inherited personality potentials. As Dr. Menninger has so ably indicated:

> The healthy development to an emotional adulthood—

and I am really quoting here—

> depends very largely on the home situation which provides affection, good example, and security.

Not only the home, but the community environment must also be considered in the development of mental disease.

Dr. Menninger explicitly acknowledges the importance of the housing shortage, unemployment, and the various prejudices and conflicts which threaten the security and comfort of the family unit.

In my original testimony, I have given statistical evidence of the interplay of these various factors on mental disease.

Senator DONNELL. Doctor, did you identify Dr. Menninger as he is identified here in the Atlantic Monthly?

Dr. FRIEDMAN. He is the same William Menninger, sir, who is psychiatric consultant for the Army.

Senator DONNELL. He is here identified as president of the American Psychiatric Association.

Dr. FRIEDMAN. Yes, sir. I do not mean to reflect on the personality, necessarily, of individual psychiatrists. I think, however, it is permissible to say that a psychiatrist is no satisfactory substitute for a secure and comfortable home or for the affection and firm support of a wholesome family life. The medical profession cannot be held responsible for the family life.

I am glad to say here, gentlemen—and this can be off the record, if you wish—there is a very significant development in this country which has not received proper notice. The Federal Council of Churches of Christ in America have recognized this problem and for 10 years have had cooperative meetings between physicians and the clergy to combat some of these problems, to recognize them, and I think it is our duty and the public duty of the Congress and the medical profession to educate the people to what these problems mean.

I think we have overemphasized the role of the medical profession. We have sadly underemphasized the importance of the church and of other wholesome influences in the communities, and I think that something might be done along those lines.

Now, to return to this, I must certainly agree with Dr. Felix that there is nothing to be gained by a return to the neglect and do-nothing attitude of the past. Conversely, there is little to be gained from exaggerating the importance of the efforts of individual psychiatrists and minimizing the importance of the environment factors which are really responsible for the production of mental disease.

For example, gentlemen, I don't know whether you recall this or not, but no matter what kind of a community one had, no matter how wealthy one was, regardless of medical care or population density, mental deficiency did not occur in Irishmen; it did not occur in Jews.

Now the medical profession can't convert all of us to be Irishmen and Jews, even if that were desirable. Chronic alcoholism does not occur in Chinamen, and I don't think we all want to be Chinamen, but there is no use neglecting these cultural, ethical, and important backgrounds, and say the psychiatrist can do it all. That is poppycock.

Once abnormal behavior patterns or mental disease have developed, it is probable that psychiatry can do some good for some individuals. However, I don't know. Even Dr. Felix wisely refrains from submitting any detailed estimates of how much good can be done, but the quantitative estimate was submitted by the Federal Security Administration.

They say, and they cite evidence which I am willing to accept for the moment, that 8.4 percent—8.4 percent of patients discharged from the mental-disease section of the veterans' hospitals—and they say on page 722—8.4 percent are regarded as cured or recovered; but, please note, "at the time of discharge."

Now, gentlemen, if we handled cancer statistics like that, or peptic-ulcer statistics like that, we would have a most brilliant medical record. Where is the 5-, 10-, or 20-year follow-up on these patients? How many of those 8 percent are going to remain cured? But leaving that aside, who can determine the curability of a chronic disease by observations on the condition of the patient at the time of discharge?

Let us grant that about 8 percent of the mentally ill can be cured. Would that have changed the draft-rejection statistics? Not one iota.

Let me quote from the mobilization records, MR–9, page 40: "Reliable history of commitment to a mental hospital will be cause for rejection." And let me urge upon you, gentlemen, that when the War Department says "commitment" they are not using that in the legal way. They don't mean that a person has to be put in there against his will, and to make doubly sure about that, I called up the Selective Service System and got a ruling on it. That is not what they mean at all. Any patient who has ever been in a mental hospital for treatment of a verified mental disease is not acceptable by the Army, whether he is cured or not.

Now we are talking about draft-rejection statistics. We are not talking about what happened to these people in civilian life, no matter how much they were cured. We are not responsible for the Army's ruling. Those men would not have been acceptable for military service by the very fact they had been patients, and if you doubt it, here is the ruling of the War Department right here [illustrating].

The FSA also claims that I did not sufficiently allow for rejection for eye diseases. That statement, gentleman, is not proven. I am fully aware that eye diseases accounted for 2 to 8 percent of all rejections, or that eye defects, rather, and that eye diseases accounted for about 40 percent of these. So that the total number of rejections for eye diseases was about 2 percent.

I make no pretense of being an expert in ophthalmology, but one of the things I did when I prepared my original testimony was to collar some of my colleagues in ophthalmology and get their opinion. So what I wrote was a distillate and the expert opinion of these ophthalomologists. We also have their opinions, of course, on these profile boards in the Army for years. I served 4 years with one hospital unit where we were doing specialist work all the time. These people assured me that, with very few exceptions, the kind of eye diseases that we encountered as listed in the draft rejection figures could not have been prevented, and very few of them could have been alleviated.

So that I was not unaware of that, but I had that in mind when I wrote my original testimony. The FSA alludes to some eye diseases and to some injuries to the musculo-skeletal system for which treatment was delayed or inadequate. They don't produce any evidence as to how many people were injured or defected because their treatment was delayed or inadequate. It is one thing to make charges like that and something else to substantiate it.

In the absence of any data that there was inadequate medical treatment, as, for example, in the case of an eye injury or delayed treatment, how can I or anybody else calculate how many of those could have been prevented? However, that isn't really the point, because I was cautious enough in making my tables to include under conditions which could not have been prevented only those eye rejections which were due to refractive errors or which are clearly not preventable. We don't know how to make an eye so that they will never need glasses. You will see that on page 658. Those are the only ones which I included in my category of unpreventables.

I expressed such caution to place blindness and other eye diseases in category 6, if you will notice, because I felt that we didn't have sufficient information to classify them, even though my colleagues told me that I would be fully justified in putting them in the unpreventable class, but I was cautious. I put them in the class I didn't know, and you will find those in my table category 6 in my original testimony. In other words, gentlemen, I was trying to be fair, and bent over backward not to include things that are unpreventable unless I knew them for a fact.

If the members of the Federal Security Administration have any evidence that a large number of these injuries or defects were due to medical neglect or delay or inadequate medical treatment, they have not presented one iota of evidence of that fact at the present time, and I think, gentlemen, that in fairness to the medical profession that charge either should be substantiated or withdrawn.

In one sentence in the last paragraph on page 695, the members of the FSA make two statements, both of which are contrary to fact.

In the first place, they attribute to me the claim that "no treatment is of any remedial value" in the treatment of a number of conditions, including asthma.

If you will note in my original testimony on page 659, the first sentence, I acknowledge what any physician knows, that the individual attacks of asthma can be treated successfully and the patient given relief. In the second place, they claim that I have listed these and other conditions as "hopeless." This statement also is flatly contrary to fact. They can cite no such statement of mine any place that any condition is hopeless.

Senator DONNELL. Doctor, as regards asthma, do you think they have in mind the two sentences near the top of page 659, where you say:

> But the attacks will come again. The patient is not cured of asthma.

Dr. FRIEDMAN. I don't know what they had in mind, but they make the sweeping statement that I say that no treatment is of any remedial value. It is one thing to say you can't cure it; it is another thing to say that the treatment is of no value. I not only didn't say that, but I pointed out that there is some value in treating a patient with asthma, as we well know, but you can't cure it. That is the difference.

I should expect that a governmental agency in reporting, preparing a report to this committee, would be accurate. I think that is not too much to ask. I wasn't satisfied with my own opinions of this, despite many years of experience with this, but I asked Harry Bernton, here in town, who specializes in allergy, and who has a terrific practice in asthma, to go through his own office records and tell me what he found. He ventured the opinion that after vigorous treatment for many years or months, depending upon the individual, about 10 percent of asthmatics could be regarded as "cured." That doesn't mean that they would be free of the disease, but it would mean that they could go for many years without any seriously embarrassing symptoms. They would have, nevertheless, some repetition of attacks, but minor ones. Even those people who would be alleged to be in this 10-percent group of "cured" would show asthmatic type of breathing if you examine them. In other words, they may feel fine and have no trouble, but you put a stethoscope on their chest and you would hear all the music you want to hear in any key you want to play it, wheezes, rumbles.

Now, this is a group of people who, even though they said they felt fine, would be rejected by the Army as asthmatic. So the number of people you can regard as cured in asthma is insignificant. That doesn't mean that medical treatment doesn't do them any good.

Senator MURRAY. Doctor, I am not trying to get any free medical advice from you [laughter], but I have heard many people complain about rheumatism and who claimed that they had been told by members of the profession that there is no cure for them. Is that true?

Senator DONNELL. Pardon me, just a minute. What was it you said before you asked that question? [Laughter.] I would like to know.

Senator MURRAY. I remember a case where a man got some free advice from a lawyer by meeting him on the street and making a bet with him that so-and-so was the law. It developed later that he was involved in a case which involved that point, and the lawyer sent him a bill for $500. I don't want you to send me any bills in this case, because I am not interested, myself. [Laughter.]

Dr. FRIEDMAN. No, sir; it is difficult to answer the Senator's question, because to a medical man the word "rheumatism" doesn't have much meaning. If you mean disabling chronic arthritis——

Senator DONNELL. What do you mean, Senator?

Senator MURRAY. The kind of rheumatism people have when they can't walk around.

Dr. FRIEDMAN. Senator Murray, I will come to that point a bit later, but that is another point about the United States Public Health Service. When people speak about "rheumatism," that might include anything. In other words, the lay person includes any kind of an ache or pain that he feels some place outside of his belly as rheumatism [laughter], a pain in the shoulder or a pain in the hip or a pain in the knee. Now that might be due to metastatic involvement of the spinal column. I would have to know the cause. Now if you are talking about disabling chronic arthritis, I hesitate to say this, but honestly, we have no cure. As a matter of fact, I am not so sure we can do much good except to teach the person how to live more comfortably with his misery.

Senator MURRAY. Eventually they may discover a cure for it.

Dr. FRIEDMAN. I sincerely hope so. I might say, since we are getting personal, that I had the privilege of treating a member of the Senator's family in the service, which we can talk about later. [Laughter.] As a matter of fact, he visited me recently. He is a very grateful patient. He is now selling lenses for Bausch & Lomb, if you know the one I am talking about. Do you recognize the physician? It is Dr. James Murray Flynn of New York.

Senator MURRAY. Oh, yes.

Dr. FRIEDMAN. We will talk about that later, but I have him as one of my grateful patients from Army days, and we are good friends. He was here a few weeks ago.

Senator MURRAY. Yes; that is right.

Dr. FRIEDMAN. Getting back to the testimony, on page 696, the Federal Security Administration charges that I have completely ignored the important fact that—

> modern medicine can control and alleviate many conditions which are not actually "curable."

That is their first sentence on Page 696. They specifically charge, among other things, that I failed to acknowledge the possibility of thus alleviating the manifestations of diabetes by the use of insulin, the possibility of alleviating asthma, which I have already referred to, and the administration of appropriate therapy in heart disease.

These statements are flatly contrary to fact. To be sure, I did not undertake to write a textbook of medicine for this committee. However, as tersely as possible, I cited the value of the medical treatment of asthma, on page 659, first sentence, and the use of insulin for the control of diabetes, fourth sentence.

In the second paragraph on page 659, I stress the importance of medical care for various cardiovascular conditions, including congenital heart disease, high blood pressure, rheumatic heart disease, and so forth. The Federal Security Administration persists in confusing successful medical therapy which will enable the individual to live a nearly normal life with the much more difficult task of curing the individual of these various diseases, and the Army was not interested in people who could get along by taking pills every day.

The Army has adopted a policy that if a man was dependent on medicine, no matter how well he looked, they wouldn't take him. That is one thing we must keep in mind.

In the last paragraph on page 696, the Federal Security Administration rebuttal charges me with classifying club foot and diabetes as conditions which are beyond the province of the medical profession. This statement, gentlemen, is flatly contrary to fact, as you can see in your own record. Neither condition was included in my table 1, page 658, which lists those conditions which I thought, however, erroneously, are beyond the province of the medical profession. Diabetes is specifically included under the endocrine disorders of table 2, page 658.

I should like to acknowledge to this committee at the present time, that for practical purposes, club foot is entirely preventable. There is no need for a young man growing to adulthood with club foot; that is beyond dispute, but this committee should realize, however illogical it may seem, that the Selective Service System did not classify club foot under the musculoskeletal system, congenital defects of which are listed in table 2. The Selective Service System classified club foot under "feet," which may seem strange to you [Laughter.]

Feet defects were responsible for about 1 percent of all rejections. Of the total number of rejections for "feet," flat feet accounted for about 80 percent of the 1 percent, and all other foot defects, including club foot, accounted for 20 percent of the 1 percent, or 0.2 of 1 percent; is that right?

Senator DONNELL. Twenty percent of 1 percent?

Dr. FRIEDMAN. Yes; that is 0.2 of 1 percent.

Senator DONNELL. It would be a fifth of 1 percent, two-tenths of 1 percent.

Dr. FRIEDMAN. All those diseases, to combine all foot diseases other than flat feet, was two-tenths of 1 percent, but included in this group was not only club foot, but six other foot defects also. Actually, the frequency of club foot was so small that the Selective Service System doesn't list it independently. You can't find out how many people there are with club feet. Nevertheless, they have no reason for objection, because I was again cautious in my table of defects which were not preventable. I included only flat feet. I was cautious enough to omit club foot and all other foot defects from that category.

So the FSA once more is in error, and I think this time it is an understandable error and an unintentional one, because I can see where they might have thought that we should have included club foot under musculoskeletal defects.

Now, gentlemen, I should like to come to an item which came to me as a complete surprise, and because the data I now have is so surprising and so recent, I have not had time to correct my original testimony that I prepared for you.

The Federal Security Administration presents a letter from a qualified physician who has expressed the opinion that:

> On the basis of present knowledge, adequate health measures, preventive and curative, could have lowered draft rejections for the various cardiovascular disorders you have listed. This statement is based on the following facts—

and so forth, page 722. Then, in the back, they gave this letter.

This, gentlemen, is a rather embarrassing thing for me, because I am obliged to differ very sharply and publicly with a man who has proper qualifications in New York, but I shall present the facts and let the committee judge.

This physician is not only in active practice in the city of New York, but has been certified by the American Board of Internal Medicine. He really should have known better. He also is listed as the medical director of the American Heart Association, which I will refer to in a moment.

Gentlemen, I should like to call your attention to the fact that he is not, never has been an officer of the American Heart Association, nor is he a member of the executive board of the American Heart Association.

When I saw that letter of Dr. Connor's, I couldn't understand how a well-qualified and intelligent physician could submit a letter of that kind. When I saw the statement, which you will see in your record, that the Federal Security Administration submits this as a letter, not from Dr. Connor, but as from the American Heart Association, they say "This is the opinion of the American Heart Association," gentlemen. I know the quality and character of the men in the American Heart Association. I felt so strongly by my own knowledge that the American Heart Association would never write or endorse such a stupid letter as came from Dr. Connor, that I took the privilege of writing the American Heart Association and asked them, "Gentlemen," in effect, "do I have to challenge you or Dr. Connor?"

I should like to submit for the record a letter which I wrote to Dr. H. M. Marvin, American Heart Association, 1790 Broadway, New York 19, N. Y. Dr. Marvin is the executive secretary of the American Heart Association. He is an associate professor of medicine at Yale University Medical School. I should like to read you this letter:

> DEAR DR. MARVIN: I have been engaged in a public controversy with members of the Social Security Administration about the interpretation of the Selective Service System data. It is the contention of this Administration that many of the rejections for cardiovascular defects could have been prevented, and thus that these rejections are evidence of a widespread medical neglect. I have challenged this interpretation on many points.
>
> In a rebuttal to my analysis the Social Security Administration has exhibited a letter from Dr. Charles A. R. Connor on the stationery of your association. Dr. Connor reached the conclusion that on the basis of present medical knowledge draft rejection for various cardiovascular disorders could have been lowered.
>
> I wonder if you would be kind enough to tell me whether this letter of Dr. Connor was shown to and approved by the officers and executive committee of the American Heart Association.

incidentally, many of which I know—

> or if the opinions expressed are to be accepted only as the personal opinions of Dr. Connor.
>
> I find myself in rather sharp disagreement with Dr. Connor at many points and am now in the process of filing a paper with the Senate committee in which these differences are to be expressed in considerable detail with appropriate reference to the literature in cardiology. This discussion of mine—

I didn't know if I were to be allowed to tell this or not—

> if accepted as testimony by the committee will, of course, be published.

I wanted it strictly on the record.

I should greatly appreciate an answer to the points I have raised, and would be very happy to forward your letter to the Senate committee along with my own discussion.

Out of courtesy to Dr. Connor, I plan to write him in the near future and inform him of the nature of our differences.

I would like to submit this letter to the committee.

Senator DONNELL. It will be received in evidence.

(The letter submitted by Dr. Friedman is as follows:)

JANUARY 21, 1948.

H. M. MARVIN, M. D.
American Heart Association,
New York 19.

DEAR DR. MARVIN: I have been engaged in a public controversy with members of the Social Security Administration about the interpretation of the Selective Service System data. It is the contention of this Administration that many of the rejections for cardiovascular defects could have been prevented, and thus that these rejections are evidence of a widespread medical neglect. I have challenged this interpretation on many points.

In a rebuttal to my analysis the Social Security Administration has exhibited a letter from Dr. Charles A. R. Connor on the stationery of your association. Dr. Connor reached the conclusion that on the basis of present medical knowledge draft rejection for various cardiovascular disorders could have been lowered.

I wonder if you would be kind enough to tell me whether this letter of Dr. Connor was shown to and approved by the officers and executive committee of the American Heart Association or if the opinions expressed are to be accepted only as the personal opinions of Dr. Connor.

I find myself in rather sharp disagreement with Dr. Connor at many points and am now in the process of filing a paper with the Senate committee in which these differences are to be expressed in considerable detail with appropriate references to the literature in cardiology. This discussion of mine, if accepted as testimony by the committee will, of course, be published.

I should greatly appreciate an answer to the points I have raised, and would be very happy to forward your letter to the Senate committee along with my own discussion.

Out of courtesy to Dr. Connor, I plan to write him in the near future and inform him of the nature of our differences.

Very truly yours,

MAURICE H. FRIEDMAN.

Dr. FRIEDMAN. I was unable to reach Dr. Marvin in New York and I got no reply, and when I called New York they offered to serve me up one order of Dr. Connor, but I declined and insisted on talking to Dr. Marvin, who was in New Haven.

I finally contacted Dr. Marvin in New Haven. I told him of the situation. In the telephone conversation he was surprised and indignant that any such interpretation of a letter from Dr. Connor had ever been contemplated. He said that letter was never shown to the executive committee, let alone the entire membership, but was never shown to the officers of the American Heart Association. It was never shown to the executive board of the American Heart Association, that those opinions, he said in the telephone conversation, are to be regarded only as the opinions of Dr. Connor.

I then requested that Dr. Marvin write both to me and to the committee a letter addressed to Senator H. Alexander Smith, of New Jersey, stating these views, and Dr. Marvin said, "I would like to have Dr. Connor write that letter," and he said, "furthermore, I shall see to it in the future that if Dr. Connor wants to write any more letters, he will bring a box of his own stationery to the office and not use the stationery of the American Heart Association." [Laughter.]

I have here a copy of the letter from Dr. Connor, and I think Senator Smith should by this time have the original, because I asked that the original be sent directly to you.

Senator SMITH. I asked this morning for it in my office, but it wasn't there.

Dr. FRIEDMAN. This is the way it came to me. It should be addressed here to you, sir. I had it addressed to this room. I didn't know what time it would get here.

Senator SMITH. I will ask Mr. Rodgers if he received it.

Mr. RODGERS. No.

Dr. FRIEDMAN. It is probably around some place, because this is dated January 27. This is from Dr. Connor:

> MY DEAR SENATOR: I have been requested to clarify for you a statement written for Mr. Watson Miller on the date of July 9, 1947.
>
> This statement, as was indicated in the accompanying letter to Mr. Louis S. Reed—

whoever he is—

> represented my own opinion and not those of the American Heart Association.

Now there is one other thing which I don't understand. Maybe Dr. Marvin was wrong, but he told me that Charles Connor was not appointed to his present title as medical director of the American Heart Association until September 1947. Now it is quite possible that Dr. Marvin is in error about the date; I don't know, but that is what he told me over the telephone, and if I may, I would like to submit a copy of this letter.

Senator SMITH. It will be admitted.

(The letter presented by Dr. Friedman is as follows:)

AMERICAN HEART ASSOCIATION,
New York 19, N. Y., January 27, 1948.

Senator H. ALEXANDER SMITH,
Chairman, Senator Committee on Education, Labor, and Public Health, Washington, D. C.

MY DEAR SENATOR: I have been requested to clarify for you a statement written for Mr. Watson Miller on the date of July 9, 1947.

This statement, as was indicated in the accompanying letter to Mr. Louis S. Reed, represented my own opinion and not those of the American Heart Association.

Sincerely yours,

CHARLES A. R. CONNOR, M. D.,
Medical Director.

Dr. FRIEDMAN. I should now like with great pleasure to consider the points raised by Dr. Charles Connor.

Senator SMITH. Does that appear in the record that we have here?

Dr. FRIEDMAN. Yes, sir; it will.

Senator SMITH. What page is that?

Dr. FRIEDMAN. I cited that, sir. The letter from Dr. Connor is at the back of the testimony. It is at the tail end. I can find it here.

I should like to say for the record, therefore, that the Federal Security Administration has—I don't know; I wouldn't say intentionally; I am not saying about their intentions—they have misrepresented a letter from a private physician as being the official opinion of the American Heart Association.

Senator DONNELL. The letter is the one set forth in appendix B, is it, Doctor, at page 722?

Dr. FRIEDMAN. Yes, sir.

Senator DONNELL. And is referred to at page 696?

Dr. FRIEDMAN. That is right.

Senator DONNELL. The language is:

> In a special statement referring to the Friedman document, the American Heart Association commented—

and so forth?

Dr. FRIEDMAN. Correct.

I submit that that is a misrepresentation of fact. As a matter of fact, gentlemen, there is no evidence whatsoever that the alleged Friedman document was ever shown to either Dr. Connor or to any member of the American Heart Association. I think the inference is a highly improper one.

I should now with great pleasure like to discuss some of the points Dr. Connor has brought up. I am glad to be able to agree with Dr. Connor that bacterial endocarditis can now be treated successfully, but when Dr. Connor says it can be cured, it is stretching things a little bit. At the present time the mortality rate from this disease is about 30 percent, which is still bad enough, but much better than we ever did before. But granting that it is completely curable, I should like to bring to the attention of this committee something else which Dr. Connor failed to do.

In the first place, it is so rare that it had no statistical significance in the draft rejection. If you gentlemen will pardon me, I will just skip that. I can demonstrate that it is of no significance, but I want to show you the falseness of this statement. The important point is that with rare exceptions, so rare that they are published, bacterial endocarditis does not attack a healthy heart. It attacks the heart of rheumatic fever or it attacks the heart of congenital defects. I cite here from Paul White's book, which is a classic in American literature, the fact and also from some of his published works—the citation is in my paper—that in a recent survey he made, 82 percent of the cases of bacterial endocarditis had been engrafted upon rheumatic heart disease and another 14 percent upon congenital heart disease, and another few percent on miscellaneous kinds of heart disease.

In other words, gentlemen, even if we could cure 100 percent of the cases of bacterial endocarditis, Dr. Connor's statement would be a silly one, because the Army would still reject the people, for the fundamental diseased condition upon which bacterial endocarditis was engrafted, namely, rheumatic fever; congenital heart defects would still remain. So that is a very silly statement.

Senator SMITH. Doctor, if you would prefer to summarize the balance of your report there, we would be glad to publish the whole report in the record.

Dr. FRIEDMAN. Yes, sir; as you prefer, but so much was made of this document.

Senator SMITH. If you would give us, I think, a summary and put it in the record, if Senator Murray would be glad to consent to that——

Senator MURRAY. I listened to your testimony with great interest, Doctor.

Senator SMITH. I think you have been giving us a very fine presentation of this issue, and we are very glad to have it in the record.

Dr. Friedman. I will just refer to the general principles now; you will see the details in here.

To say that because we have penicillin now or that because we have surgery now we will correct these diseases, doesn't mean that we could have prevented these defects when these young men were growing up. We don't know how to make penicillin available retroactively. We don't know how to cure heart disease retroactively. We cannot take penicillin and cure heart disease which was present 15 years ago, which is what they are asking us to do. We can't take surgery for rheumatic heart disease and say that we should have prevented the draft rejection of these boys who have been growing up 10 or 15 years ago and came to World War II.

Senator Donnell. Pardon me a moment. The whole statement of the doctor is going to be in, is it not?

Dr. Friedman. I would like to have it in.

Senator Smith. Yes. I want the whole statement in. It is a very carefully prepared analysis.

Senator Donnell. Mr. Chairman, I might call attention to the fact that this statement that the doctor is rebutting consumes a very large amount of space in the record, I think.

Dr. Friedman. Yes. It was with considerable effort that I got all through it. I don't think that I really finished, gentlemen.

Senator Donnell. It begins at page 686 of the record and runs down through about the middle of page 721. Then there are certain appendixes which which are attached.

Senator Smith. Middle of page 726.

Senator Donnell. Well, that is approximately 40 pages of rather small type.

Senator Smith. I might say there, Senator Donnell, that pages 723 to 726 is an exchange of correspondence between Senator McGrath and myself. So it starts on page 686 to 723.

Senator Donnell. That is approximately 37 pages. I don't know what the size of that type is, but it is pretty small and there are a good many tables there.

Senator Murray. I was going to observe that it would have been nice if we could have found the practice they found where a legal question is concerned. They sometimes get together with an agreed statement of facts, instead of this long drawn out——

Dr. Friedman. There are competent scholars in the Government with whom that would be entirely possible. Dr. Dunn, in Vital Statistics, is a man with whom I could easily reach an agreement on these matters; there are others in Public Health Service and various others, but these statements made by lay persons, unqualified to make them, is something entirely different.

Senator Donnell. Mr. Chairman, this is obvious, but I would just like to have it noted specifically in the record that this whole subject matter that the doctor is discussing with such care this afternoon is one of tremendous importance, particularly in view of the great emphasis which has been laid so many, many times upon the results of the Selective Service investigations.

Senator Smith. With the emphasis on the large percentage of rejections.

Senator Donnell. Yes, sir, and while it may seem at moments that we who are not doctors can't understand all the technical language, this rather lengthy discussion that the doctor is giving us is a very exceedingly valuable discussion.

Dr. FRIEDMAN. Whatever the gentlemen prefer. I don't want to tire you.

Senator DONNELL. Let me just ask you this. This need not be on the record.

(There was a discussion off the record.)

Dr. FRIEDMAN. I am free to admit that I have certain prejudices which I would be glad to lay on the table, but I have been a scientist for long enough years, and I could discard those and I could easily reach agreement with other experts, if I may include myself, on matters of fact.

Senator MURRAY. Doctor, I would be very glad to have you go ahead and complete your whole statement.

Senator DONNELL. Might I ask the doctor, Do you have any knowledge as to who it was that actually prepared this analysis which appears on pages 686 to 721, to which the appendices have been appended?

Dr. FRIEDMAN. No, sir. I am just a private doctor. I don't know what is going on down here.

Senator MURRAY. If you want to go into that, Doctor, it will take two or three more days, and we will have to call a lot of witnesses here, because I understand they collaborate on these things.

Senator DONNELL. I just wondered if the doctor had any knowledge as to who actually did this?

Dr. FRIEDMAN. No, sir. Personalities don't interest me. I try to steer clear of that.

Senator DONNELL. I am not particularly interested in the personalities except to know whether or not these men who prepared this document from page 686 on are men who have the requisite experience and training and knowledge, who have something to give us of real value.

Dr. FRIEDMAN. It has been presented by Mr. Miller, I think.

Senator DONNELL. I started to say a moment ago it is signed—I don't see it is signed by anybody. I see that appendix A is signed by R. A. Felix, medical director.

Dr. FRIEDMAN. No. He was a physician, I believe, in the Public Health Department.

Senator DONNELL. But the document itself, the analysis of Maurice H. Friedman, Ph. D., M. D., to the committee, and so forth, prepared under the direction of the Federal Security Administrator. I don't see that it is signed by anybody. Am I wrong on that?

Dr. FRIEDMAN. Mr. Miller apparently is responsible for some of it. What I don't understand is that if Mr. Miller is responsible, how is it this letter of Dr. Connor was sent to Mr. Reed? I don't get that.

Senator DONNELL. Pardon me, Doctor. The point I was getting at is we have here an analysis answering the testimony which you gave, and the analysis doesn't give us the benefit at all, so far as I observe here, of who it was that prepared it. So we can't bring in anybody without going through the process of some inquiry of Mr. Miller or somebody else. The testimony you have given previously comes out over your name or under your name, as the case may be, and we know to whom to look.

Dr. FRIEDMAN. I will accept responsibility for that.

Senator DONNELL. But I can't find anything here at this glance I am giving it that would indicate who prepared it. Now it may appear here somewhere; I may not be correct.

Dr. FRIEDMAN. I keep referring to Federal Security Administration because I wasn't interested in personalities, and I had no knowledge of who they were.

Senator DONNELL. Mr. Miller himself, of course, has very frankly stated to our committee numerous times that he is not a doctor himself, and obviously he didn't prepare it. It says it was prepared under his direction.

Dr. FRIEDMAN. Mr. Miller apparently undertook to lecture me on medical subjects, however.

Senator DONNELL. It is noted here, Senator Smith calls to my attention, the fact that the letter of transmittal is over the name of Maurice Collins, Acting Administrator. Do you know Maurice Collins?

Dr. FRIEDMAN. No, sir.

Senator DONNELL. Do you know whether he is a doctor?

Dr. FRIEDMAN. I know nothing about him.

Senator DONNELL. Well, go ahead.

Senator MURRAY. We'll subpena Mr. Collins, Watson Miller, and a few of the others over there and set aside a couple of days probably so that we can get to the bottom of it.

Dr. FRIEDMAN. There is one important point that Dr. Connor brings up. As I said, many of these things are just piddling; they are not statistically significant, but he mentioned a very important statement, which, if true, would have shown me to be seriously in error. That is regarding rheumatic fever.

Rheumatic fever is a very important segment of heart disease and a very important cause of rejection among draftees. Now Dr. Connor admits that we cannot in our present state of affairs prevent the first attack of rheumatic fever. He also admits that in a large number of cases, the heart is seriously affected with that first attack. In other words, we cannot prevent the heart disease resulting from the first attack of rheumatic fever. He does say, however, and this is where I should like to challenge him or cite authority to the contrary, that by prophylactic use of a sulfonamide and penicillin, we can prevent recurring attacks of rheumatic fever and thus in some cases, perhaps, rheumatic heart disease.

Now I admit there are papers in the literature which have been enthusiastic and optimistic that say we could prevent the recurrence of rheumatic fever by the prophylactic use of sulfonamides. I really wish that were true. I really wish that were true. However, I have cited some authorities here which deny that. I have cited one authority, for example, Dr. May Wilson, who does nothing but work with rheumatic children in a sanatorium in New York, who says, and I give the reference in my testimony:

> I would not have given it (sulfonamide) in the first place. Until it can be definitely shown that prophylactic chemotherapy prevents recurrence—

and she goes on to show why it can't be shown.

> It is inadvisable to use a drug which may in some instances have deleterious effects.

Now that is not a joke, gentlemen. I have a woman in my own practice who has lost the sight of her right eye because she liked to take sulpha medicine for a cold. Sulpha doesn't do a bit of good for a cold and it is a dangerous drug, and should never be taken without a prescription; even then it is taken. We have a disease called periarteritis nodosa, which is fatal, for which we have no cure, and the largest number of cases of periarteritis nodosa is due to the indiscriminate widespread use of sulpha compounds. So a wise physician would refrain from giving sulpha compounds to rheumatic children unless the evidence were clear that it was effective. My own view is, I wouldn't say that it is not effective. I say that it is debatable. Many authorities deny that it is effective.

At a public meeting of our staff at Mount Alto Hospital a few months ago, Dr. Arnold Rich, the famous pathologist of Johns Hopkins University Medical School, denied there was any evidence whatsoever that sulpha medication would prevent rheumatic fever. He cited from his autopsy material the great danger, the great number of cases of periarteritis nodosa resulting from a widespread, ill-advised use of sulpha compounds. I say that it is debatable, to put it mildly. I personally do not know of any evidence that penicillin will affect the recurrence of rheumatic fever.

I challenge Dr. Connor to produce one scrap of evidence to that effect. If such exists, I do not know of it. Nevertheless, here we are again. We can't take sulpha now, we can't take penicillin now and prevent rheumatic heart disease these boys had when they came out for the draft board in World War II.

Senator SMITH. You mean it is not retroactive?

Dr. FRIEDMAN. Correct. Just as in law, the lawyers and the doctors agree that penicillin is not retroactive. [Laughter.]

Senator DONNELL. Or ex post facto. [Laughter.]

Dr. FRIEDMAN. Or any of those other big words.

Dr. Connor is unquestionably correct in his statement that almost all cardiovascular syphilis can be prevented by early medical treatment. We have already discussed the necessity of bringing the patient to the doctor. Syphilis is a funny disease. You have got to bring the patient inside. The syringe wouldn't reach him at long distance. Actually, the rejections for cardiovascular syphilis amounted to only 2 percent of all rejections for syphilis, and since syphilis accounted for about 9 percent of all rejections, cardiovascular syphilis was responsible for about .02 percent of rejections.

In sections 7 and 8, Dr. Connor admits that nothing could have been done about either hypertension, which was responsible for 37 percent of cardiovascular rejections, or arteriosclerosis, which was insignificant. As a matter of fact, I am a little more hopeful about hypertension than Dr. Connor is. I have got patients in my own practice and we are doing something for them, but because we can enable a cripple patient to get up and walk across the room from his chair, it doesn't mean that the Army can make a combat soldier out of him.

In brief, Dr. Connor hasn't submitted one iota of evidence which would in any way alter my original testimony, and I submit that to any group of impartial experts.

On page 697, the Federal Security Administration, in their rebuttal, take up my discussion of rejection among Negroes in the population of Southern States. It was indeed my intention to show that the

Negro had fewer curable defects, or any defects of any kind, than the white population. The record shows that; it is perfectly clear.

Contrary to the statement of the FSA, this matter is not determined by definition. The full list of defects cited in Selective Service System Bulletin No. 3 shows 29 classes of defects, each of which may be further subdivided into more specific types of defects.

Of these 29 classes of defects, the Negro had higher rates in only 5, and I would like to read you those: Educational and/or mental deficiency, gonorrhea, syphilis, cardiovascular, but the selective-service people are careful to point out that the only reason that the Negro made that showing there was because of the higher incidence of high blood pressure in the Negro, about which we can't do anything anyhow about it from the standpoint of prevention and very little for cure, and the other category was "other medical." Those are the five.

In the remaining 24 classes of defects, the white man had much higher rates of defects than the Negro in every category except the 5 I have just mentioned. So that isn't a matter of definition.

Senator MURRAY. How do you account for that, on the basis that they got more medical care?

Dr. FRIEDMAN. No, sir. That is the point I am making. I would like to read you my summary there. I cited that. I cited the lower defects in the Negro. I don't mean to say he is getting better medical care. As a matter of fact, gentlemen, I am pretty sure he isn't. The only reason I cited those Negro rejection statistics was to show how foolish it was to try to draw any conclusions about the health of the community because of rejections.

I would like to read you one point which I made that was in my summary. I wanted to show how very silly it was to try to draw any conclusions from those defect rates. I quote from point 9 of my original summary, my original testimony. It isn't in your book, Senator. That is the part that is omitted:

> The futility of attempting to use the selective-service data for any discussion of medical care is placed in bold relief by the data on tuberculosis. All surveys of the Selective Service System show and confirm the higher incidence of tuberculosis in the white man, higher than in the Negro.

If we were to use the same kind of logic as that employed by the proponents of compulsory health insurance, we might conclude that with respect to tuberculosis, the Negro was receiving better care than the white man. I say that is what we might conclude.

My closing sentence, gentlemen, is put in capital letters. I didn't explain it, gentlemen. I thought it would be perfectly obvious—

> but the death rate for tuberculosis is much higher in the Negro than it is in the white man—

and that is the point I am driving at. You can't take one isolated bit of statistics and judge community health and medical care from that. It is perfectly inadmissible.

In medical statistics Bulletin No. 3 they claim my conclusions based on an analysis of table 6 are untenable. Inasmuch as I drew no conclusions from table 6 they are now saying that the no conclusions which were drawn were untenable. I don't know whether to agree with that or not.

On page 698, paragraph 5, however, the Federal Securitiy Administration makes a perfectly legitimate point, and I admit the validity and justice of that point regarding the defect rates for all the whites and Negroes who were called for examination under Selective Service and Training Act. They say table 7 is apparently free from the deficiencies which have been pointed out in table 6, but when the basic data from which the table was compiled are analyzed, it becomes apparent that the defect rates for Negroes and whites are actually not comparable. During the period of that particular one I happened to sit——

Senator DONNELL. You are referring now to paragraph 5?

Dr. FRIEDMAN. The fifth paragraph on page 698.

Senator DONNELL. Beginning with the word "presumably," and ending with the words "table 6"?

Dr. FRIEDMAN. Yes, sir. I think the point they raise there is legitimate. Theoretically the point is very legitimate, and I will tell you why. During that period of time the local draft board had the privilege of rejecting men if they had some gross defect like syphilis or mental deficiency. Therefore, when they took a Wasserman and came back positive, those men did not get the complete examination at the induction station.

Those men who were rejected by the draft board were probably—I am not sure, but possibly they had only one recorded defect, even though, actually, they might have had many others. Inasmuch as twice as many Negroes, to be sure, were rejected by the local board as white men, that would artificially lower the tabulated rejection rate for Negroes. That is perfectly true. I admit that.

Dr. Rowntree discussed it with you at some time, and he thought it was insignificant, but I am bringing up the point now. But here is the point: For the period covered by Selective Service Bulletin No. 2 and No. 4, that objection does not hold because this period covered by No. 2 the men at the draft board got a complete examination so that is wiped out there. They got a complete examination, and, as medical statistics, Bulletin No. 2, said, every defect was recorded. Now, unless we want to disbelieve selective service, we have got to take their word for it, but if you look at the analysis which I show here, the number of recorded defects for Negroes in that period was still lower than the whites. It is no different from what I cite in Bulletin No. 3.

Also, in Bulletin No. 4, instead of complete examination being done at the draft board, now the local draft boards had lost all of their functions for all practical purposes, and all registrants received complete examination at the induction station. So the point is that, even if they want to reject for the period of Bulletin 3, which is a valid, theoretically valid point, that objection does not hold for the period preceding that or the one following that; nevertheless the Negroes showed a lower rate of defects in both of those periods. That is merely a matter of fact. I am not drawing any conclusions from it, but I am merely saying that the Federal Security Administration is again in error.

Before discussing in any detail the significance of these data on the Negro I should like to call attention to one statement made by the Federal Security Administration on page 699, paragraph 3, to the effect that rural rejection rates were higher than urban. It so happens that that statement is also flatly contrary to the fact, and I have here a reproduction of table 55 in a forthcoming publication of the Selective Service System which has not yet been published. I want to get that because it is important. I am sorry, but I do not find it at the moment.

Senator MURRAY. Submit it for the record.

Senator DONNELL. Could you supply it for the record, Doctor, and just go ahead with your testimony?

Dr. FRIEDMAN. I will do that. It shows briefly that for the Continental United States as a whole, and for every section—they break it down by sections—the rural population has a lower rejection rate than the urban.

Senator DONNELL. You will include that in the record, will you, Doctor?

Dr. FRIEDMAN. Yes, sir. Now, the situation for the Negro is something different. For the Negro the rates are about the same in our rural areas, where it is a little bit the other way around for the urban, but for all practical purposes the rural rejection rate for the Negro is about the same as it was for the urban; but for the white man the rural rejection rate was consistently not only for the United States as a whole but for every section of the country lower.

I think the reason for some of the confusion is the following: When you compare, let us say, farm rejection rates with nonfarm you are doing something there which is not making a fair comparison, because a large or disproportionate part of the farm population is in southern United States, and a large part of that population is Negro, so we are not comparing the white rural worker with the white urban worker; you are comparing the southern Negro with the white northern industrial worker. That is about what you are doing. When you break it down to the white rejection rates and Negro rejection rates that factor no longer operates. The white race shows, as I said, a lower urban rejection rate in every section of the country. I am sure I can find it before we close. I have the exact figures. I have got the manuscript here with me if you would like to have it, or I will read it to you.

Senator DONNELL. Did I misunderstand you there? I understood you to say there was a lower urban than rural rate. Did you mean that?

Dr. FRIEDMAN. No, I meant the rural rejection rate was lower than the urban; the rural population showed up better on those statistics than the city population.

Senator SMITH. That is for the whites?

Dr. FRIEDMAN. For the whites. I have got the table here.

Senator DONNELL. I think you said it the other way.

Dr. FRIEDMAN. Then I am sorry. Let me correct it.

Senator DONNELL. Suppose you state it again, so we will get that clear.

Dr. FRIEDMAN. For the white population the rejection rate of the rural people was lower than for the city people, not only for the entire United States but for every section of the country. I can read you these figures here. They will come out in table 55 in a publication which is about to come out. I saw the original data of the Selective Service. Here are the actual figures.

Senator DONNELL. What publication is that? Are you at liberty to tell us?

Dr. FRIEDMAN. Yes. I forget the title of it, but it is going to display the Selective Service data for 1941 and 1944, inclusive.

Senator DONNELL. Is that an official publication?

Dr. FRIEDMAN. Yes, from the United States Selective Service headquarters. I went down to Selective Service and had them approve every item in this table, so I know it is correct.

For the United States as a whole, for white only—now, I don't want to be confusing. I put these in the reverse of what I have told you, because I didn't want to change their table. They have listed these as acceptances rather than rejections, so, in order not to mess around with the table, I continued it just as it is. These are acceptance rates, the number of men accepted per hundred examined in the continental United States.

Out of every 100 men examined, 54.7 were accepted for military service. That is for cities. In rural it is 57.3. In other words, more rural men were accepted for military service per hundred than urban, in the whites.

Senator DONNELL. Wait a minute, Doctor. That is 54.7 in the cities?

Dr. FRIEDMAN. Correct.

Senator DONNELL. That were accepted?

Dr. FRIEDMAN. Yes, and 57.3 in the country.

Senator DONNELL. Or, state it the other way, 54.7 accepted were urban and 57.3 were rural?

Dr. FRIEDMAN. Yes, sir. These are acceptance rates, general acceptance rates. That is the way they express it, so I didn't want to change it.

For the eastern United States the rates were urban, 52.3; rural, 53.1. Again, I don't think it is significant but the figures happen to be higher, that is all.

For the South the urban rate is 56.6, and the rural rate is 59.

For the Midwest the urban rate is 55.6, and the rural rate is 57.9.

For the far West the urban rate is 56.5 and the rural rate is 57.8.

Now, I should like to call your attention a moment to the statement that Leonard Rowntree made before this committee some years ago, in which he stated that, in his opinion, the best boys on the farms never came up for examination; that, in his opinion, the cream of the crop was kept at home on the farms—I have got the exact quotation in my paper—and were classified as 2C or 3C, and kept on the farms and never showed up at the induction station. I don't know whether he is right or wrong, but that is his opinion stated before this committee. If that is true, despite that fact, the rural acceptance rates are higher and the rejection rates are lower than the urban.

Now, to be quite fair with the commitee, that condition I have just shown you does not obtain for the Negro.

Senator MURRAY. I don't know whether the statement you have just made is true or not, but I do know that in my State several farmers came to me who claimed that they were unable to operate their farms, that they were crippled up and unable to operate the farm, and wanted to have their sons examined but were unable to do so. So I think we ought to check into that a little more.

Dr. FRIEDMAN. Yes; I am not pressing the point. I am merely citing the opinion of Leonard Rowntree, because he has been so frequently cited before, and I want to cite both sides of it. That is all.

For the colored population the acceptance rates in general were lower than they were for the whites.

For the continental United States the urban rate was 48.6, and the rural rate was 47.7 somewhat lower.

For the eastern United States the discrepancy was even larger, 51.8 accepted in the cities, but only 48.6 in the country.

For the South 56.5 were accepted in the city and 59 in the country. I checked those figures and they are right according to the Selective Service, though I don't understand them.

For the Midwest, 51.7 for the city and for the rural population 50.4.

For the far West 45 for the city, and somewhat higher for the country, 47.1.

In other words, it seesawed back and forth, and the net result was about the same for the city and country for the colored man, and definitely in favor of the country boy for the white population.

I think that to clear the record that should be inserted. I have prepared the tables, and if I have time I can give them to members of the committee.

Senator SMITH. I think you had better check with the reporter when he gets out the record, to be sure that those figures are right.

Dr. FRIEDMAN. I will submit the table here for the record.

(The table referred to follows:)

TABLE 55.—*Showing the percentage of men accepted for military service, by region and community size*

[From unpublished data of the Selective Service System]

Area	Urban	Rural	Area	Urban	Rural
Section A, white registrants:			Section A, white registrants—		
United States	54.7	57.3	Continued	55.6	57.9
East	52.3	53.1	Midwest	56.5	57.8
South	56.6	59.0	Far West		

Area	Urban	Rural	Area	Urban	Rural
Section B, colored registrants:			Section B, colored registrants—		
United States	48.6	47.7	Continued		
East	51.8	48.6	Midwest	51.7	50.4
South	56.5	59.0	Far West	45.0	47.1

Senator SMITH. When you get the record I want you to check it to see that the figures are correct.

(Subsequently Dr. Friedman verified the figures in the transcript.)

Dr. FRIEDMAN. I don't know how much further I should go.

We now come to the distribution of medical facilities, page 699 of the record. This really should not be properly in my sphere, but I have tried to learn something about it.

I have here a statement, a quotation attributed to an officer of the United States Public Health Service. I can not vouch for its accuracy because I have not heard it myself, but it is quoted in this medical journal, a United States Public Health officer who states that in his opinion we are not prepared to say how many physicians are needed per thousand population.

Senator DONNELL. What publication is that?

Dr. FRIEDMAN. This is Medical Annals of the District of Columbia, for October 1947, and appears on pages 567 and 568.

Senator SMITH. Is that a monthly publication?

Dr. FRIEDMAN. Yes, sir.

Senator SMITH. What month is it?

Dr. FRIEDMAN. October 1947, No. 10. I will give this to the committee.

Senator DONNELL. Is the quotation very long?

Dr. FRIEDMAN. No, sir.

Senator DONNELL. Suppose you just read it into the record. Do you know what doctor it was who said it?

Dr. FRIEDMAN. It is not a doctor. This is Mr. Theodore Wiprud, who is editor of this journal. I have looked for it and I cannot find a written record of it, but he is usually pretty reliable, so I think it is probably all right. In trying to find out how many physicians we need—he is talking about Washington here—he said:

> Your observer looked for that answer in the report, but it wasn't there. The reason, the surveyors said, is that there is no basis for determining the proper ratio of physicians to population. Dr. Ciocco pointed out that no one has yet defined adequate medical care. Until this is done, the number of physicians needed for a given population cannot be definitely ascertained. At the present time those who seek the answer to this question must be satisfied to base their conclusions on the demand for the services of physicians.

I would like to get that in the record to show that, despite these grand calcuations that we sometimes try to make, I think there is some reason for wanting to know just what the truth is.

Senator SMITH. Does that mean, Doctor, that on page 699, table E, where it says, "Number of physicians required to meet the present need for individual preventive services," you think that, according to this quotation you have just made, there is not really adequate data from which to draw those conclusions?

Dr. FRIEDMAN. That is right. And in my original testimony, as a basis for argument merely, I cited the figures of Lee Jones as a basis of estimate. They thought that, for treatment and diagnosis only—I thought the Public Health Service would take care of the other things, but the treatment and diagnosis only they thought that 1 physician to every 1,200 population would be adequate. I don't know whether that is right or not, but I must admit this: to the extent that I did not include, as Lee Jones did, doctors for other purposes, I was in error. I am perfectly willing to admit that, but I would like to call to the attention of this committee and to the public the things which are not widely appreciated.

I do not have with me the exact number of doctors who entered the Army and Navy, but I think it was on the order of about 50,000. Is that about right? I know it is something on that order. In other words, during the war years the number of doctors available to the civilian communities was decreased by about one-third, but the actual volume of service decrease was greater than that, because the younger and more vigorous men were in the Army, so that a very conservative estimate is that the medical service of this country suffered a decrease in manpower of at least 33 percent during the war. Despite this fact, from 1938 to 1945, the period covered by the war, infant mortality in the United States dropped from 51 per thousand live births to 38.3.

Senator DONNELL. Do you have any idea how many physicians went to war before our country got into the war? We didn't get in until December 8, 1941, did we?

Dr. FRIEDMAN. No, sir; but that is a very pertinent point, Senator Donnell, and I have the information relative to that here too, because I have brought with me the vital statistics on that point. I did that merely as a summary, but even during the war years there was a very definite step-by-step decrease. I shall be glad to read this to you. This is vital statistics summary, special report. There was a perfectly steplike decrease in maternal mortality through 1940 and 1941. Would you like to have me give that?

Senator DONNELL. Start with 1940 and up to December 8, 1941.

Dr. FRIEDMAN. In 1940 the maternal mortality rate as stated in this publication, United States Vital Statistics, was 3.8 per thousand live births. It decreased year by year steadily to 2.1 in 1945. I mean it is not a question of comparing it before our doctors went to war. Take it any way you want to take it, it is still there.

In addition to that, during this same period of time also in a steplike way, our maternal mortality rate dropped from 4.4 to 2.1 per thousand live births.

Now, gentlemen, you cannot take the statistics or changes in statistics and say that these changes are due to one factor, like the number of doctors, because here you have decreased the number of doctors by 33 percent, and your health statistics are getting progressively better. If you want to draw conclusions that way, the thing to do is to get rid of the doctors. If you take one-third of them away, you get along better. Maybe that is right. I don't know, but that is where that kind of conclusion and that kind of logic drive you to; don't you see?

Senator DONNELL. Do you think the conclusion is valid, Doctor?

Dr. FRIEDMAN. Well, being, in addition to a physician, a scientist, I refrain from comment until I have better evidence.

Senator MURRAY. The conclusion so far from your testimony would be that we had a great many rejections because we had good medical care in the country.

Dr. FRIEDMAN. To some extent that certainly was true.

Senator MURRAY. And we would have been better off if we had no medical care at all.

Dr. FRIEDMAN. You would not have any rejections at all?

Senator MURRAY. That is right.

Dr. FRIEDMAN. Well, no; you would have some.

Senator SMITH. You would have corpses.

Dr. FRIEDMAN. You would have corpses. You would have such as the Czechoslovakian greenhouse workers who chopped off their hands. You would have people like that. I don't know whether the oboe players had anything to do with this or not.

Now, we come to another point, and again I think this is a mistake. In all these discussions before the committee we have heard so many counties are without doctors and so many counties are without general hospitals. Now, I do not imply that the Senators who use those arguments are willfully stating something that is wrong, but I think they were badly informed. I think it is very unfortunate. I know that they would not willingly use bad information if they could get better, and I would like to get better information. The Federal Security Administration now admits, page 700, paragraph 1, that the county is a poor unit of comparison. The Public Health Service pointed that out 4 years ago. Despite that fact——

Senator Donnell. Pardon me, Doctor, but so that we will have in the record just what it says, I quote from page 700:

> Dr. Friedman is correct in stating that the county is a poor unit for measuring the adequacy of medical facilities. Most investigators have employed it only for want of better data.

Dr. Friedman. That is right. In my original testimony, gentlemen, I cited a good example of that when I cited the conditions around Denver, Colo. Every place that I go in this country I try to learn something about medical care. Now, around Denver there are three or four counties—Arapahoe is one of them—you will find it in my testimony—in those counties around Denver, each one of them is listed as having an insufficient number of doctors, and it is true. If you put it on the per-thousand basis, they do not have many. But what happens? In those counties practically the entire population of the county, 70 or 80 percent, is nestled around metropolitan Denver. All you have got to do is step across an imaginary line and 70 or 80 or 90 percent of the population is right there. The rest of the county has a lot of rocks and cabins and coyotes and very few people—and no doctors. But the people who live on the fringe of metropolitan Denver not only have their own doctors who are listed in that county, but they use all the facilities of metropolitan Denver. So if you say that this county is in such terrible condition because it has no doctors or no general hospital, that is not facing the facts, and that is exactly what I have tried to bring out.

Senator Smith. I can corroborate that. I lived in Colorado Springs for about 15 years, and I know that the people from the counties around there, Pueblo, Lincoln, Keller, all came into Colorado Springs, where there was very excellent medical service and an excellent hospital. I am familiar with the raising of the money for the hospital. It served a lot of the rural population.

Dr. Friedman. I think it is a mistake to base the need for physicians on a county basis after you look at these cities, and 40 percent of our counties contain only about 8 percent of our population, 10,000,000 people. Isn't that right? I mean that has been broken up and distorted beyond recognition. It has no place in any honest discussion of our medical needs. I am sure that if we took an honest look we would find some districts in this country that need more medical facilities, but let us be honest and find out where they are, and not list so many counties and so many people without doctors.

I am glad to accept table H on page 702, in rebuttal. I am perfectly happy. I don't question that at all. I presume table H is correct. It shows that the number of calls per physician in small towns is somewhat lower than it is in cities. I think that is probably correct, but that is not the whole picture either.

Senator Donnell. That particular table covers the period from 1928 to 1931, some years back.

Dr. Friedman. Yes; but I won't even press that.

Senator Donnell. I wanted the record to show that so it will be apparent that the figure is not necessarily of today.

Dr. Friedman. No; it is not. It may be better today. It may be worse, for all I know. I have no knowledge of that.

This reports per case of illness the rural physicians' calls, and here in the rural areas the number of calls per case of illness was only about 80 percent of that in the small towns, and only about 70 percent of the number in the larger cities. If you work it out in percentages, that is about what it means. But the FSA does not contest the accuracy of reproduction of the data in my original presentation. They cannot, because I have quoted their own statistics. They admit on page 703, for example, that diphtheria immunizations were more frequent in the rural areas than they were in the cities. They also admit that physical examinations are more frequent in the rural areas than they were in the cities. Their only comment on this point is that I combined these things in my table, which I did, because I reproduced one of their tables which had already combined them.

I have already discussed the question of distribution of medical care, and I will not spend more time on that.

Senator DONNELL. In regard to your statement about physical examinations in rural areas, I am not sure that I understood it. I cannot keep up with the figures here. I note that on page 703 the FSA says:

> Physical examinations, curiously enough, were most frequent in towns under 5,000 (89.3 per 1,000 population), but least frequent in rural areas (52.6).

Dr. FRIEDMAN. That is right. Apparently they have broken that down. In their original publication of the Committee on Cost of Medical Care those two things were combined. They had one heading there, which I reproduced and which they do not contest. They put the headings "Physical examinations" and "Immunizations" in one category, so naturally I reproduced that and showed the rural areas to be better off than the urban. They discussed here why that should be.

Senator DONNELL. They say here on page 703, referring to table J, "In the table shown by Dr. Friedman, these two are combined." The table that you showed was their table?

Dr. FRIEDMAN. That is their table; yes, sir. I did not tamper with their table. I just took it as it was, and I refer to my text to the original publication, the original table, and they do not charge me with either misrepresenting that or misquoting the table—nor can they.

I also believe that we have given insufficient attention to the mobility of our population in rural areas, and I think that is important. We cannot compare these various indices of health and medical service in the rural areas in this country with the rural areas in Czechoslovakia or Denmark because of the automobile, our American system of highways, and the tremendous gift that private industry in the way of automotive industry has made to the American people wherever a man—most people can own an automobile, most farmers do.

Senator MURRAY. In some States, such as Montana where many of these people are 70 miles away from a railroad station or from a community, it is not so good out there.

Dr. FRIEDMAN. I don't know about the roads out there. I will say this: I happen to be vice president of an aviation corporation, in addition to a few other duties, and the sales of airplanes, private airplanes, in Montana and the far West is higher than it is in any other part of the country. The farmers out there are buying airplanes. They are not bothering with automobiles.

Senator MURRAY. That is right.

Dr. FRIEDMAN. I don't want to make too much of that, but I mean we do have to consider that this country is not like Denmark, not like Czechoslovakia or Bohemia or any other "hemia." We have got something here that is different. We must recognize that.

Senator DONNELL. Senator Murray, you have an excellent system of highways in your State, generally.

Senator MURRAY. We have very good highways in Montana now, in the last 15 years, since the New Deal came in.

Senator DONNELL. The record will show that that is not entirely new to the New Deal.

Dr. FRIEDMAN. I might say that when you say a patient is 30 miles from the nearest hospital, actually our counties are not more than 30 or 40 miles across in this part of the country. I don't know how they are out West.

Senator MURRAY. When I was out in Montana this summer I picked up a paper one day and saw that in one county in the northwestern part of the State they had had an epidemic and there was no physician in the county. I was in another county 2 years ago where there was only one doctor left, and he was preparing to leave because he was not able to make a satisfactory living there. He had a family and could not afford to stay.

Dr. FRIEDMAN. I think those are important things, and instances like that should be brought to our attention and they should be corrected, but I don't think we are getting any place by covering up the picture with all this extraneous and false information.

On page 703, here again the Federal Security Administration does not challenge the verity of the factual material submitted in my original testimony. They do claim, however, that I have overlooked the relation of economic status of the receipt of the care and the necessity for period health examinations. These statements are made on 704 also, paragraph 2—the presence of actual illness in some patients who are unaware of it and therefore do not report it.

Page 704, paragraph 5. That I have not overlooked these factors can be seen by reference to my tables 10, 11, 12, 14, 17, and 18 in my original testimony, where I stress these relations, economics, to income, in great detail, and particularly do I stress this in the first paragraph on page 667, which I could read for you but which you can read for yourselves.

Members of the Federal Security Administration cite a poll conducted by the National Physicians Committee, which reported that about 30 percent of the persons interviewed by them said they postponed going to a doctor because of the cost.

The decision to spend a certain part of the family income on medical care rather than on certain other expenditures is colored by the spending habits of the individuals and their particular evaluation of the importance of medical care, and I do not want to repeat that. I have gone into great detail, showing that even in very low-income families they spend more on the private use of automobiles, more on things that are in the nature of gifts, more on everything, than they do on medical care. It is not my province to decide whether they should do that or not, but, gentlemen, if we are going to say that medical care is a necessity, if it is something worthy the attention of the Congress of the United States, if it is to be classed as food, clothing, and shelter, as an important element in our lives, then people should not be encouraged to spend their money on other less necessary items, and be subsidized for medical care.

Now, it is amazing—I can show you here in my original testimony tables gotten up by governmental agencies, not my figures, tables showing the spending habits of low-income families. I am not saying that they should not buy any liquor, that they should not gamble on the races, or that they should not do something else; but we should make up our minds whether we are going to consider medical care akin to food and shelter and clothing, or are we going to consider it as an optional expenditure which must compete in the budget with all these other optional expenditures. I think that is a very important consideration.

Senator MURRAY. Of course, there are some things they cannot escape. They have got to have shelter and food.

Dr. FRIEDMAN. Yes, sir.

Senator MURRAY. And if they spend all their money on shelter and food, how are they going to take care of the medical end of it?

Dr. FRIEDMAN. May I, with the permission of the Senator, read some of these expenditures?

Senator MURRAY. I read in the paper the other day about a man who came down here from New Jersey to testify before a committee. He was earning the immense sum of something over $2,500 a year, and I understand that they had not been able to get meat more than once every 10 days or something of that kind, and he could not afford to buy milk; it was too expensive. He had several children in his family, and there was no possible chance for him to set aside any earnings to pay for medical care.

Dr. FRIEDMAN. That is true, and I hope the times we are now going through are not the normal times to be expected.

Senator MURRAY. They are abnormal now, in the sense that we are getting a higher income, more people are earning $2,500 a year now than ever before in the history of the United States, and yet people earning that amount, or even $3,000 a year, are unable to pay for medical care.

Dr. FRIEDMAN. Yet I believe I am correct in saying that the official publications of the Bureau of Labor Statistics show that real wages have actually gone up. I don't know whether that is right or not.

Senator MURRAY. Real wages have gone up?

Dr. FRIEDMAN. I mean by "real wages" purchasing power despite the high cost of living. That is what they tell me. I sometimes doubt it myself, but I think you will find that the Bureau of Labor Statistics will show that the buying power of the present workman's take-home pay is greater than it was before, despite our high prices. I am not saying it is enough. I am not justifying that, but I should like to read some interesting things. For example, in table 21 of my original testimony I reproduced some data from an official publication which I would like to read to you. This is on page 675, table 21.

In the first place I should like to call your attention to the fact that families which are listed with a premium of zero to $249 a year, actually spent $927 a year, and Margaret Hollingsworth, who conducted the survey, commented on that:

> We must reckon with the fact that these people have other resources than what they reported as income.

I mean—you can look at that table at your leisure—I want to point out that, as a matter of fact, the people who are listed in these statistics as having zero to $249 income per year, actually spent more money per year than anyone until you get up to the $1,000 to $1,249 class. These are quotations directly from the work that I have quoted here, reference table 22—I have forgotten its exact title.

Now, if we turn over to page 676, we see the distribution of income for optional expenditures, broken down as to food, clothing, and shelter. I then show what the people spent for other things.

Table 22, page 676. People who are listed as having an income from zero to $249 spent $224 for optional expenditures; I mean, expenditures for something other than food, clothing, shelter, maintenance of household, things like that. Of this $224 optional expenditures, they spent $33 for medical care, they spent $39 for the family use of an automobile, and Miss Hollingsworth was careful to point out that that does not include any use in any way connected with the farm. I simply wanted to call attention to that point.

They spent $11 on tobacco; and on gifts and taxes, $71; recreational only $4.

I am not going to judge how these people should spend their money; but you can just see, when you go up, you will notice, interestingly enough, that no matter how the lower-income families spent their money, they spent as much on tobacco as the wealthiest families in the country. I am not saying they should not smoke. but those are facts as reported by Miss Hollingsworth.

When we get to about the $1,500 or $1,749 group, the total optional expenditures are $341; medical care has increased a little bit, from $33 up to $46, but the family use of the automobile has jumped to $140 a year. Tobacco is about the same. The poor man smokes just about as much tobacco as anybody else.

Gifts and taxes are less, and recreation is listed at $21.

I am not saying that these people should spend all their money for medical care. I think part of the question is one of education, no matter what kind of system we have, even if we take it out of taxes, you have got to get the people prepared to be willing to spend money for medical care if they are going to buy it.

I will be glad to have table K submitted in rebuttal on page 705. To be sure, medical attention increases somewhat with increased income. I am speaking now of this table from the Public Health Service, I believe it is, table K, page 705.

Senator Donnell. The National Health Survey.

Dr. Friedman. That is right. That was data actually accumulated from the National Health Survey conducted by Isidore Falk and others in 1928 and 1929, and the dates worked over again by the Public Health Service. That is merely another way of showing what I have shown you in my original testimony.

If you will note, the groups that were not on relief, the self-supporting population, going from the lowest-income groups up to the highest, a rise of over 500 percent in family income is accompanied by only an increase of 18 percent in the volume of medical care. In other words, whatever that economic factor is, it is not as big as people have been making it. Here you have got an increase of 500 percent in the family income, and an increase in medical services of about 18 percent. As a matter of fact, if you took in the next column, the number of doctors' calls for disabling cases, an increase of over 500 percent in family income was associated with an increase of 16 percent in the number of calls for disabling illness.

I mean that the question of economic barrier, whatever it is, has been exaggerated, I think. The reason for the exaggeration is that doctors are a bunch of peculiar people. They treat sick people for nothing if they need it. I think we should not lose sight of that fact, and I think it is unfair to vilify the medical profession by claiming that we are insensitive to economic needs, when you know, and everybody else knows, that we frequently give our services for nothing or for little cost to people who really cannot afford to pay for it. I think that factor should be considered.

Those figures really are no different than the data I presented to this committee earlier, and are submitted in my original testimony. To appreciate each of these figures, however, one should keep in mind that the number of aged people—I mean by that people over 45 years of age—is greater in the higher-income groups than it is in the lower-income groups. That is a very important point ,and I believe that until I presented my testimony no one had ever told this committee anything about that.

In the survey conducted by Mr. Falk and his coworkers, if you look at their distribution of population sample—I discussed that in my original testimony—I have got a table on it—the number of old people in the higher-income group was over twice as great as it was in the lower-income group, over twice. Now, when we know that old people get sick more frequently and that each illness is more serious, when you say that the higher-income groups are getting more care, of course they are going to need more care if they have got more old people in them, and that factor was never brought out in this presentation of Falk's testimony or any other testimony about the cost of medical care. I discuss that in some detail in here, and I will not refer again to that.

The Federal Security Administration states that the PCMC found that illness occurs with much the same frequency among rich and poor, which is not substantiated by the original data of Falk himself. I have reproduced these data in table 13. The Federal Security Administration has not and cannot challenge the accuracy of this table. These data show that the incidence of illness, the frequency of illness, was 40 percent higher in the upper-income groups than it was in the lower, so that their need for medical service is greater, not less, as you have been frequently told. Is that clear? From their own data, the data of Mr. Falk and his coworkers submitting costs on medical care, the frequency of illness was 40 percent higher in the highest-income group as compared to the lowest. That is in my record. I am sure you have got a copy of it there.

Senator MURRAY. How do you account for that? Is it because they have no money to spend?

Dr. FRIEDMAN. No, I think Dr. Falk says that frequently they have more sickness. I am not saying they can afford it.

Senator MURRAY. Why do they have more sickness? Is it because they are more extravagant?

Dr. FRIEDMAN. No; I don't know, Senator Murray. I think one factor is—this is a guess, and that was not brought out—that they have more old people among the higher-income groups, and old people get sick more frequently than younger ones. I think that is one big factor that has been utterly neglected in all of our estimates of medical care.

I should like to point out to this committee that the population sample which was studied by the National Health Survey of 1935 and 1936 was not identical with that studied by Mr. Falk, because in their study too there were more old people in the upper-income groups, but the distribution was not quite the same in the highest-income group. The people over 45 years of age amounted to 30 percent of the population in that group; in the lower-income groups they amounted to about 20 percent of the population. In other words, the proportion of old people increased by 50 percent as you went up—that is, from 20 percent to 30 percent, an increase of 50 percent—it increased by 50 percent as you went from the lowest-income group up to the highest. So, even with the National Public Health Survey we would have to expect more serious illness in the upper-income groups.

Now, the point is that in trying to frame legislation on these national questions I think it is our duty to find out: Is the population sample studied by Mr. Falk and his coworkers in 1928 truly representative of the difference in income groups, or is it as expressed by the Public Health Service? In other words, what is the true distribution by age and by income groups in the United States? Maybe Mr. Falk is right. Maybe the people of the United States Public Health Service are right. Maybe neither is right, but I don't see how we can possibly frame legislation to cope with health unless we know something about the population we are dealing with. If we may be perfectly ridiculous and say that in the low-income groups all the people are young, we have got to have more diapers; if we have them all old in the upper-income groups, we have got to have false teeth—I know that is ridiculous. I am just showing the relationship. I know the babies have no bills for false teeth because we don't give them false teeth, but the point is that before we can frame legislation intelligently we have got to know for whom we are framing the medical care, and the population sample discussed by the National Public Health Survey is not the same distribution by income and age as Mr. Falk's sample. I am not saying that was willful or that there is anything wrong about it. I just don't know which one represents the truth; in other words, which is the most representative sample.

And if we stop to think we must realize that as a man grows older, if he is honest and if he is a good worker, his income goes up. I mean that is one part of the picture. Of course, you get to the point where the incomes goes down again too, but we have got to consider that. This is particularly true of chronic illness like cancer and high blood pressure. These are serious things. We don't have to worry so much about the little sniffles. In fact, in my own practice I tell the patient to go to bed. I don't even go to see them. But the increased amount of sickness with old people is important, and if we find more old people in the higher-income groups than we do in the lower-income groups, we must take cognizance of that factor.

Senator SMITH. We will have to close very soon. It is now five o'clock, Doctor.

Dr. FRIEDMAN. I will just cite one instance here. I am not objecting, or I do not want to cast any unfair aspersions on the public health survey of 1935 and 1936, but we must recognize its limitations, as was frankly stated to me by men in the Public Health Service in private conversation, the people who conducted that poll were relief workers—I have nothing against them—that have taken the relief rolls without any previous medical training or any technical training.

I admit, as the FSA says here, that they gave preference in their selections to white-collar workers, but they also say that they gave them training for about 10 days. A 10-day training period is not adequate for an untrained person to get sufficiently informed about medical subjects to conduct that kind of a poll, and it shows, gentlemen, in the result. Let me show you a few things.

Of 35,000,000 cases of chronic illness listed by the National Health Survey, 7,000,000 were labeled "rheumatism." In other words, 20 percent of all chronic disease compiled was placed under a label which is meaningless from a medical standpoint. According to Bulletin No. 9 of the National Health Survey, rheumatism is defined as arthritis, gout, neuralgia, neuritis, lumbago, acute rheumatic fever, stiff neck, and other muscular pains. Those are not my words. They are the definitions of the National Health Survey.

Senator SMITH. You probably suffer a number of those things yourself?

Dr. FRIEDMAN. That is right. Maybe I should have been in there too among these 7,000,000 people. In other words, any kind of ache or pain referred to the extremities, anything outside of the belly was rheumatism. I submit, gentlemen, that that is not a proper evaluation of national health.

I could go on with this, but I think I will close. I don't want to bore you. The whole thing is here.

The Federal Security Administration was kind enough to give me a little lecture on statistical methods. I appreciate that, but I think I have demonstrated that I can handle some of these things without their help.

I specifically acknowledge on page 688, despite their statement that age adjustments are not only permissible but necessary for specific purposes, as I have already acknowledged in my original testimony given here last year, so their complaint about my meaning of "age adjustment" is hardly in order. The only reason I mentioned it was this: that in presenting these materials to the Congress or to nontechnical people it should be prominently and specifically stated when data are adjusted for age and when they are not adjusted for age. That is all. And, as I just said, in computing the health needs of the Nation we are interested in the actual composition of the population. We are not interested simply in finding out how much care they would need. In considering the $1,200-income group we must consider also the ages in that group.

Now, I don't think I will bother you any further. I could go on here and discuss these tables in detail, but the only point I would like to make is I think that the evidence submitted by the Federal Security Administration on technical and medical problems is an unsound picture, distorted, completely unwarranted. They have made a number of statements which, without impugning their intent at all, are, by the record, gentlemen, contrary to fact. I have cited instance after instance, records, statements contrary to fact, and so demonstrated by your records and by mine. I have cited one instance where the Federal Security Administration has misrepresented the opinion of a private physician as being that of the American Heart Association. If a private individual has done that I would say he didn't know any better, but I think the Federal Security Administration should know better. I don't think that is permissible.

Senator DONNELL. I would like to interrupt you just before you close. You undoubtedly have given a great amount of work and time to this study.

Dr. FRIEDMAN. Yes, sir.

Senator DONNELL. I am sure our committee is very grateful to you for it. Now, you will not take offense at this question, I know, but I think we ought to have it in the record here, as to whether any organization or anybody has either paid you or has obligated itself or himself to pay you for your services in this matter.

Dr. FRIEDMAN. I am glad you asked that question, and if you will give me a few minutes I will tell you why and how I got interested in it.

Senator DONNELL. Tell us first whether anybody has compensated you or is going to compensate you.

Dr. FRIEDMAN. I have received no compensation for this at all. All the labor has come out of my two hands and all the expenses out of my own pocket. I have been helped to the extent that after I had prepared this matter for presentation to the Congress, a friend of mine, Mr. Kirkpatrick, of the chamber of commerce, owns a mimeograph machine and he mimeographed some additional copies. Except for that kind of aid, all the labor, all the cost, physical and otherwise, has come from me. I represent no organization, as I told you before. I have been asked to join some. I was asked to join the National Physicians Committee. I have refused, because I don't want to represent any organization. I want to represent myself as an impartial person, I hope, who offers his aid to the Government. I am glad to be of any help I can. But so far, I must be frank with you, there is one other thing. I have been offered $400 if I would write an article for a magazine. I have not accepted that yet, but they have offered me that. That is for a general article on the problems related to this question.

Senator DONNELL. But for the services that have been involved in the preparation of all this data, both your original testimony some months ago and this testimony today, I understand you have not been paid by anybody, nor has anybody agreed to pay you anything. Is that right?

Dr. FRIEDMAN. Yes, that is right. The only persons who have aided me in any way are my few colleagues, Harry Burns, Bill Foote, Dorothy Holmes, specialists in these other fields—the whole crowd got together on this testimony.

The genesis of this paper, gentlemen, was when I was an officer in the Army I was shocked by what I read in the newspapers coming out of Washington. I knew it was not true, and I could not speak then because I was a soldier.

Senator SMITH. You mean by that the reasons for the percentage of rejections.

Dr. FRIEDMAN. Yes. I was working with F. D. every day. I knew it was wrong, and I made a firm resolution then, and I told Bob

Needle "If I ever get out of this man's army, the first thing I am going to do is to write this monograph," which I have done. As a matter of fact, the reason I first testified before you was sheer accident. I had never had any intention of coming before a Senate committee. I wrote this monograph only at the request of the medical editor of Time magazine, who then refused to use it. Dr. Shearon later heard of this and kept after me for months to come down here and testify. I didn't want to enter into any controversy at all and I said, "No, thank you, I am just a doctor. I don't want to." Finally I was told that this thing was valuable, that I really owed it to the committee to come down here, and only after a year of coaxing I came down and presented this thing in June 1947. That was the genesis of this document.

Senator SMITH. Doctor, I want to thank you sincerely for your contribution, which I think is a very important one. We are all very glad to have it.

The committee will stand adjourned until tomorrow morning at 10 o'clock.

(Dr. Friedman submitted the following paper:)

THE DRAFT-REJECTION FIGURES

(P. 691)

The FSA correctly states my opinion that the draft-rejection figures give no real indication of the health of our people. They do cite the opinions of Dr. Leonard Rowntree who regarded the draft-rejection figures somewhat more seriously than I do. In support of Dr. Rowntree's opinions, however, there is submitted no detailed analysis either of the draft rejection data or of the basic considerations which led to my conclusions. Nor do the members of the FSA submit the opinion of any other officer of the Selective Service System or the opinion of any other physician, with or without detailed analysis, that the draft-rejection figures are to be taken as a real index of the health of our people. In view of the number of physicians who have testified in favor of S. 1320 and its predecessors this hiatus in the rebuttal of the FSA is a glaring one.

I am content to have the record show that there is some difference of opinion betwen Dr. Rowntree and myself. Nevertheless, it should be pointed out that the opinions of Dr. Rowntree are not necessarily to be regarded as the opinions of other officers of the Selective Service System. Indeed, the following citations from the official publications of the Selective Service System are evidence to the contrary:

"There seems to be little doubt but that most of the registrants being classed as available for limited military service and a substantial portion of the registrants being classed as disqualified for any military service in the United States Army possess health conditions which would be acceptable for military duty in any army in continental Europe.[1]

"In addition to the nondisqualifying defects, a large proportion of the disqualifying defects are minor insofar as health conditions are concerned. * * * The loss of an index and middle finger, the loss of a great toe, or the fact that a registrant is less than 60 inches in height is sufficient cause for rejection, but such conditions do not indicate that the registrant is in poor health * * *."[2]

"Failure to meet the relatively strict standards then in force did not necessarily mean that the rejected man was seriously handicapped for a useful role in civilian life or for many kinds of noncombatant service in the armed forces."[3]

* * *[3]

The FSA persists in trying to defend its statement that one-half to two-thirds of the defects among rejectees could have been prevented or rehabilitated with timely medical care. Where is the factual justification for this statement?

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[1] Selective Service System, Medical Statistics Bull. No. 1, p. 10, footnote 2.
[2] Ibidem, p. 10, par. 3.
[3] Selective Service System, Medical Statistics Bull. No. 2, p. 3.

Again they cite Dr. Rowntree, but all he ventured was an estimate that about 15 percent of the rejections were for remediable defects. My own estimate was that a maximum of 18 to 20 percent of rejections could have been influenced by medical care. To date the members of the FSA have not been able to produce a statement from a single physician to substantiate their own higher estimate. Therefore, their estimate must be regarded as one derived from an analysis of technical, medical problems by lay persons altogether incompetent for such task.

SIGNIFICANCE OF SELECTIVE SERVICE SAMPLE

(P. 692)

The first statement made by the FSA under this heading is flatly contrary to fact. At no time have I made any statement charging the Selective Service System with failure to indicate clearly the limitations of their population samples. Indeed, my only source of information on this point was the Selective Service System. Their official publications clearly warned against these limitations, and I have referred appropriately to these warnings in my text and bibliography (text, p. 657; bibliography reference 5, p. 3). I should like to quote one of these warnings now:

"* * * However, several pertinent factors have often been neglected in public discussions of these rejection rates. (1) A large number of physically fit registrants chose to enlist in the armed forces without awaiting induction through the Selective Service System. If they had entered the armed forces through Selective Service the records would show larger numbers of inductions, the same number of rejections, and lower rejection rates."[4] This is precisely the point I made in my original testimony (p. 657). Members of the Selective Service System, so far as I am aware, cannot properly be classed among the proponents of compulsory health insurance, so that my statements could not possibly be construed as referring to them.[5] Quite properly classed as such proponents, however, are the members of the FSA who failed to bring to the attention of this committee these very pertinent facts. Nor have they reminded the committee that many of the men who were deferred were probably better physical specimens than the average of those submitting to induction examinations. In Dr. Leonard Rowntree's words: "* * * * but I think, too, there is the factor of agricultural deferment, in which the cream of the crop is kept for work on the farms. You see, a great many of them were rendered II–C or III–C and were not sent up for examination. I think that perhaps the best group of all is in that agricultural deferment group."[6]

FACTORS GOVERNING REJECTION RATES

(P. 692)

The FSA states that the publications cited by me emphasize the prevalence of defects and not the proportion of men rejected. This statement is flatly contrary to fact, as can be readily seen by anyone who will inspect the Selective Service bulletins cited in my bibliography.

ANALYSIS OF CAUSES OF REJECTION

(P. 692)

Although the thesis of the FSA has not been so succinctly expressed, it seems to be something like the following: (1) Diseases or defects for which there are remediable therapeutic procedures should not exist; (2) any existing cases of such diseases or defects are to be regarded as evidence of medical neglect; (3) the extent to which such diseases or defects exist is a measure of the inadequacy of medical care, due either to the maldistribution of medical facilities or to an economic barrier.

Despite our wishes in the matter, we must face the hard facts of life. For more than 10,000,000 men, for a period of over 4 years, the armed services eliminated completely the factors of distribution of medical facilities and the cost of medical care. Did this eliminate disease? Specifically, did this wipe out venereal disease?

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[4] Selective Service System, Medical Statistics Bull. No. 2, p. 3.

[5] P. 657, sec. I, first sentence.

[6] S. Res. 74, 78th Cong., p. 1645.

As a matter of fact, the armed services did more to control venereal disease than eliminate the factors of distribution of medical services and the cost of medical care. They had special venereal disease control officers who carried on vigorous campaigns to teach the men how to avoid exposure and how to take fullest advantage of all medical facilities if and when exposed. Prophylactic supplies were made available to enlisted men free of charge, and they were taught how to use them. Prophylactic stations were provided in towns and cities adjacent to military installations. These were situated in convenient locations and kept open all night. Surprise inspections were conducted by medical officers at frequent intervals at 3 or 4 o'clock in the morning in order to pick up infected men who had not reported their disease. In some instances organizations with extraordinarily high venereal disease rates were confined to the military installations with no privileges to visit the neighboring communities. In some instances whole units (companies, or squadrons) were confined in barbed-wire enclosures with no chance to visit other sites on the military reservation, such as the PX or the post theater.

Despite such vigorous measures venereal disease was rampant in every military installation at home and abroad. What is more interesting is that the venereal disease rate in colored men was from 10 to 15 times the rate in white men.[7] Did the Army and Navy provide inferior medical service for the colored men? Or, are we to infer that the cost of medical services was higher for the colored man than for the white man?

How are we to explain the fact that under the conditions existing in the armed forces the ratio of the venereal disease rate in the colored man to the venereal disease rate in the white man was exactly the same as that revealed by the Selective Service examinations? Indeed, I say that "the provision of adequate medical services, completely free of charge, will not prevent venereal disease." [8] The venereal disease problem is fundamentally one of education and of social and moral discipline.

ON THE CLASSIFICATION OF MENTAL OR EDUCATIONAL DEFICIENCIES

The FSA objects to my classification of mental and educational deficiency in a category entitled "beyond the province of the medical profession." I am not only content, but eager to accept their statement [9] that a significant proportion of mental deficiencies are of environmental origin. But we should remember that we are now discussing "mental or educational deficiency" specifically as recorded in Selective Service statistics and as related to military service. It has been repeatedly emphasized that "mental deficiency and educational deficiency are generally grouped together for purposes of discussion. The line of demarcation between the two groups has never been clearly defined." [9] "Only a small portion of the group was comprised of morons, imbeciles, and idiots." [10] Granting that some cases of mental deficiency are environmental in origin, that some originate in birth injuries (p. 693) does that change matters? Are the physicians responsible for the "environment"? Are we responsible for the distribution of educational facilities in this country? Would wider distribution of medical care at lower cost prevent these birth injuries? Where is the testimony of qualified experts that the medical profession is responsible for the occurrence of these mental and educational deficiencies?

With the citation of cretinism the FSA are tilting at windmills. All endocrine disorders accounted for only 1.5 percent of all rejections.[11] Of these, all thyroid disorders of which cretinism is but one constituted only 21 percent.[12] Hence, even if cretinism were assumed to constitute all rejections for thyroid disease, which is preposterous, it could not account for more than 0.3 percent of all rejections.

Actually, cretinism is rare in this country although it was once quite common in endemic goitre regions of Italy. This condition occurs in the offspring of women suffering from iodine deficiency and hypothyroidism. I agree entirely with the FSA statement on page 693, paragraph 3, that cretinism is susceptible to correction by early and appropriate medical care. But this does not mean that such care will cure the individual. The stricken person would have to take adequate doses of thyroid substance daily for the rest of his or her entire life. It was the general policy of the armed forces to reject men who were dependent upon daily medication for the maintenance of their health. This general policy applied with equal force to diabetics who could be maintained in good health by daily injections of insulin.[13]

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[7] Personal Communication from Mr. Eugene Hamilton, Division of Medical Statistics, Surgeon General's Office, Pentagon Building, Washington, D. C.

[8] P. 658.

[9] Selective Service Bull. No. 3, p. 26.

[10] Ibid., p. 38.

[11] Selective Service System, Medical Statistics Bull. No. 3, table 1, p. 63.

[12] Ibid., table 5, p. 123.

The incidence of cretinism, as opposed to the well-being of the individual cretin, is not readily influenced by the distribution of medical care or the cost of medical care. It is readily influenced by the distribution of iodine in the water and vegetables consumed by the people. Cretinism can be largely abolished by the use of iodized salt in those regions where iodine deficiency exists. This method is simple, cheap, and effective. We do not need any special legislation for the distribution of medical care in order to cope with the problem of cretinism.

CONDITIONS NOT PREVENTABLE AND NOT REMEDIABLE, ETC.

(P. 693)

In considering the disposition of neuropsychiatric patients in the armed forces the following points must be borne in mind: (1) The policy of the Army and Navy toward specific diseases and defects was not at all the same for men already in the service as for men being examined for induction. For example, the armed services flatly rejected men with peptic ulcer. However, those men who developed active peptic ulcer after induction were not discharged. Even after such major complications as perforation or hemorrhage these men were treated and returned to duty. Therefore to cite the fact that 70 percent of neuropsychiatric patients were returned to duty has no direct bearing on the question of altering the rejection rates for mental diseases. (2) The relatively high degree of success of psychiatric treatment in the armed forces was due not only to the early treatment, but due to the fact that a large proportion of psychiatric casualties had been well adjusted in civilian life and had succumbed only to the extraordinary mental strains incident to service in the Army or Navy. It is one thing to return to duty an individual who has succumbed to these unusual strains and quite another to try to rehabilitate an individual who had been unable to adjust himself to the ordinary demands of civilian life. Psychiatrists who have served in the armed forces are well aware of this distinction.

The members of the FSA cite the records of the Veterans' Administration and of the mental hospitals of New York State to show what can be accomplished by institutional care (p. 694, tables B and C). They allege that even these statistics underestimate the good that can be expected since "only a small proportion of the 17.7 percent of IV–F's rejected for mental disease" had serious mental disorders (p. 695). Dr. Felix, whose letter is exhibited on page 721, also remarks that "hardly more than 1 in 10 were rejected for grave mental or personality disorders."

It is quite true that of all rejections for mental disease, only about 11 percent were for conditions specifically labeled "grave mental or personality disorders." [14] Yet, another 2 percent were labeled "major abnormalities of mood, 27.3 percent psychopathic personality, approximately 6 percent chronic inebriety or drug addiction. For those who are unfamiliar with these technical terms I should like to quote the official War Department definition of some of the kinds of psychopathic personality: "In this ill-defined, more or less heterogeneous group are placed those individuals who, although not suffering from a congenital defect in the intellectual sphere, do manifest a definite defect in their ability to profit by experience. * * * They are unable to respond in an adult social manner to the demands of honesty, truthfulness, decency, and consideration of their fellow associates. They are * * * oftentimes in conflict with the law. Among this general group are three main types:

(1) Psychopathic personality with pathologic sexuality. This may include many homosexuals and cases of sexual perversion, etc.

(2) Psychopathic personality with emotional instability.

(3) Psychopathic personality with asocial and amoral trends. This includes the pathological liars, petty offenders, swindlers, kleptomaniacs, pyromaniacs, etc.[15]

It is the privilege of the FSA and Dr. Felix to exclude psychopathic personality as defined above, major abnormalities of mood, chronic alcoholism, and chronic drug addiction from the category of serious mental disorders. The consultants responsible for drawing up the mobilization regulations, the Surgeon General of the Army and Surgeon General of the Navy, and many civilian psychiatrists who collaborated with the above officers are on record to disagree with Dr. Felix and the FSA.

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[13] War Department Mobilization Regulations MR1–9, April 19, 1944, par. 83, p. 32.

[14] Selective Service System, Medical Statistics Bull. No. 3, table 5, p. 122.

[15] MR 1–9, par. 98d, pp. 41 and 42, War Department, April 19, 1944.

On the other hand about one-half of all rejections for mental disease were for psychoneurosis [16] and a large number of these could not be regarded as examples of serious mental illness. On the contrary, by usual standards these men would not be regarded as mentally ill at all. Col. William Menninger, in testimony before this committee on July 11, 1944, was emphatic in illustrating this point. He said, "* * * It has been no surprise to psychiatrists that this segment of the population has been uncovered, and is no special cause for alarm as to the mental health of the Nation * * *. It concerns our family life and educational system. It is intimately linked with the prevailing attitude of the public toward their specific service in the Army. To many men, the security of their homes and their friends and their jobs far outweigh their belief in their importance for and their need by the armed forces. The rejection of this group of men for acceptance to the Army has been widely misunderstood and misinterpreted. * * * The Army, like a football team, needs the best. * * * The fact that a man may be a regular worker, a community asset, is no indication that he can fit into the Army or be an asset to the Army. Many men can hold a civilian job with efficiency who would be unable to fit into the regimentation and discipline of the Army."

Please note that Colonel Menninger emphasizes the role of the family, our educational system, and the "prevailing attitude of the public" in determining the mental reactions of this group of men. Dr. Menninger more fully discusses the importance of such factors in an article for the general pubilc in Atlantic Monthly, January 1948. In this article he calls the attention of the lay public to the fact that the personality of an individual is formed during childhood and early adolescence by the reactions of the environment of the inherited personality potentials. As Dr. Menninger has so ably indicated, the healthy development to an emotional adulthood depends very largely on the home situation which "provides affection, good example, and security." [17] Not only the home, but the community environment also must be considered in the development of mental disease. Dr. Menninger explicitly acknowledges the importance of the housing shortage, unemployment, and the various prejudices and conflicts which threaten the security and comfort of the family unit. In my original testimony I have already cited Dr. Hyde's statistical studies on the importance of these socioeconomic factors on the incidence of mental disease.[18]

With no reflection on the personalities of individual psychiatrists it seems permissible to say that a psychiatrist is no satisfactory substitute for a secure and comfortable home, or for the affection and firm support of a wholesome family life. The medical profession cannot be held responsible for the family life in this country or for the environmental factors which threaten the security and comfort of the family. One must certainly agree with Dr. Felix that there is nothing to be gained by a return to the neglect and do-nothing attitude of the past. Conversely there is little to be gained from exaggerating the importance of the efforts of individual psychiatrists and minimizing the importance of the environmental factors which are really responsible for the production of mental disease.

Once abnormal behavior patterns or mental disease have developed it is probable that psychiatry can do some good for some individuals. Dr. Felix wisely refrains from submitting any detailed estimate of the curability or prognosis of the various types of mental diseases, but he does proceed to point out the benefits some patients might obtain in mental hospitals (p. 722). The members of the FSA submit evidence that after complete hospital treatment 8.4 percent of patients discharged from the hospitals of the Veterans' Administration were considered cured at the time of discharge. If we treated cancer statistics like this the record of the medical profession would be a brilliant one. Where is the 5-, 10-, or 20-year follow-up on these patients? Who can determine the curability of a chronic disease by observations on the condition of the patient at the time of discharge? [19] Let us grant that about 8 percent of the mentally ill can be "cured" by present-day treatment in a mental hospital. That would not have made one iota of difference in the draft rejection figures. Here again we are confronted with the difference between the ordinary requirements of civilian life and the specific qualifications set forth in the mobilization orders. According to these orders, "Reliable history of commitment to a mental hospital will be cause for rejection."[20] In view of the official interpretations of this sentence the number of cures effected by treatment in a mental hospital would not have affected my original estimates in the slightest degree. Any patient discharged as cured from a mental hospital would automatically be ineligible for induction by virtue of having been treated as patient in such hospital.

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[16] Selective Service System, Medical Statistics Bull. No. 3, table 5, p. 22.
[17] Atlantic Monthly, January 1948, p. 71.
[18] P. 648.
[19] Table B.

The FSA claims (p. 695, par. 5) that I have made no allowances for rejections, other than mental diseases, which could have been prevented by early and adequate medical care. I wish to assure this committee that I have not ignored the question of eye diseases in my estimates. I am fully aware that rejections for eye diseases accounted for 2 to 8 percent of all rejections, and that of these eye diseases at times accounted for about 40 percent; i. e., something like 2 percent of all rejections. My colleagues who specialize in ophthalmology assure me that with few exceptions the eye diseases encountered in the rejectees could not have been prevented. They also assure me that only a very small number could have been treated with sufficient success to make them acceptable to the armed forces. The FSA alludes to some eye disease and to some injuries to the musculoskeletal system for which the treatment "was delayed or inadequate." In the absence of any data whatsoever I am unable to estimate the number of cases whose rejection was due to inadequate or delayed treatmenrt. The committee will note that under category 2—not preventable, not remediable—I included only those eye rejections due to defective vision; i. e., refractive errors (p. 658). I exercised sufficient caution to place blindness and other eye disease in category 6, undetermined, because I felt that we did not have sufficient information to classify these cases. I did this despite the opinion of the ophthalmologists that most of these eye diseases could not have been either prevented or remedied, and that a significant number of the cases of blindness were due to injury. If the members of the FSA have evidence that any significant number of rejections due to eye diseases or amputations, etc., were actually due to delayed or inadequate medical treatment they have not yet presented it.

In one sentence in the last paragraph on page 695 the members of the FSA make two statements, both of which are contrary to fact. In the first place they attribute to me the claim that "no treatment is of any remedial value" in the treatment of a number of conditions, including asthma. On page 695, first sentence, I acknowledge what any physician knows, that the individual attacks of asthma can be treated successfully and the patient given relief. In the second place, they claim that I have listed these and other conditions as "hopeless." This statement also is flatly contrary to fact. The members of the FSA can cite no such statement of mine.

The successful treatment of the individual attack of asthma is entirely different from curing the disease. One of my colleagues, Dr. Harry Bernton, specializes in allergy. From his own records of many years of practice he estimates that of all patients with asthma only about 10 percent could be regarded as "cures" after long periods of intensive treatment. Even these people would not go indefinitely without some minor asthmatic episodes at one time or another. And of this 10 percent, a certain number would give objective evidence of the presence of asthma during physical examination even though they were completely symptom-free at the time. Dr. Bernton, therefore, substantiates and endorses my classification of asthma for analysis of the selective-service statistics.

On page 696 the FSA charges that I have completely ignored the important fact that "modern medicine can control and alleviate many conditions which are not actually 'curable' " (first sentence). They specifically charge, among other things, that I failed to acknowledge the possibility of thus alleviating the manifestations of diabetes by the use of insulin, the possibility of alleviating asthma, and administration of appropriate therapy in heart disease. These statements are flatly contrary to fact. To be sure I did not undertake to write a textbook of medicine for the private use of this committee. However, as tersely as possible I cited the value of the medical treatment of asthma (p. 659, first sentence) and the use of insulin for the control of diabetes (fourth sentence). In the second paragraph on page 659 I stress the importance of medical care for various cardiovascular conditions, including congenital heart disease, high-blood pressure, rheumatic heart disease, etc. The FSA persists in confusing successful medical therapy which will enable the individual to live a nearly normal life with the much more difficult task of curing or erasing the diseased condition so that the Army or Navy would accept the individual for military service.

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[20] MR 1–9, par. 98, sec. b4.

In the last paragraph on page 696 the FSA rebuttal charges me with classifying clubfoot and diabetes as conditions which are beyond the province of the medical profession. This statement is flatly contrary to fact. Neither condition was included in table 1, page 658, which lists the conditions beyond the province of the medical profession. Diabetes is specifically included under the endocrine disorders of table 2, page 658. I should like to acknowledge to this committee that with our present knowledge clubfoot is, for practical purposes, completely preventable, so that with adequate medical care this condition need not exist in persons in the draft age. But the committee should realize that the Selective Service System did not classify clubfoot under the musculoskeletal system, congenital defects of which are listed in table 2. The Selective Service System classified clubfoot under "feet." Feet defects were responsible for about 1 percent of all rejections (table 7, SSS Bull. No. 4, p. 12, No. 3, table 1, p. 63). Of the total number of rejections for "feet," flat feet accounted for about 80 percent, and all other foot defects, including clubfoot, accounted for 20 percent (SSS Bull. No. 3; p. 27). Included among this group of "other foot defects" were not only clubfoot, but 6 other types of foot defect (SSS Bull. No. 2; table 7, p. 35). In my classification of foot defects, I was careful to place only flat feet in my table 2 (p. 658), and exclude from this table the group of miscellaneous foot defects which amounted to about 20 percent of rejections for feet, and about 0.04 percent of all rejections. These rejections should have been placed in table 5, or undetermined, since the information available does not permit adequate analysis. Their omission from this table constitutes an unintentional error.

CONSIDERATIONS CONCERNING REJECTIONS DUE TO CARDIOVASCULAR DEFECTS

The FSA presents a letter from a qualified physician who has expressed the opinion that: "On the basis of present knowledge, adequate health measures, preventive and curative, could have lowered draft rejections for the various cardiovascular disorders you have listed. This statement is based on the following facts * * *," page 722. This physician is not only in active practice in New York City, but has been certified by the American Board of Internal Medicine as a specialist in that field. He is also listed as the medical director of the American Heart Association. He is not, however, an officer of the American Heart Association, nor a member of the executive board. I have written the executive secretary of the American Heart Association to find out if Dr. Connor's letter was shown to and approved by the officers and the executive board. I have asked specifically whether or not Dr. Connor's letter represents the opinions of the American Heart Association. I am submitting to this committee a copy of my letter to this organization, and shall include their reply if any comes in time. Until that time we must suspend judgment on the statement of the FSA that "the American Heart Association commented" (p. 696, par. 2). As a matter of fact it is not really clear if Dr. Connor, or any other member of the American Heart Association, actually saw "the Friedman document," since no reference to it is made in Dr. Connor's letter.

Not knowing, therefore, whether I am now challenging Dr. A. R. Connor, or the entire American Heart Association, I should like to raise the following specific points with regard to Dr. Connor's detailed discussion (pp. 722 and 723).

1. Bacterial endocarditis

I am glad to be able to agree with Dr. Connor that a large percentage of these cases can now be cured by adequate doses of penicillin. At the present time the mortality rate from this disease is only 20 to 30 percent. However, there are some very significant points which Dr. Connor has not acknowledged to this committee.

A. In the first place this condition is so rare that it has no statistical significance in the draft-rejection data. In the period covered by SSS Bulletin No. 2, about 3,000,000 men were examined. In all these examinations only three cases of bacterial endocarditis were recorded (table 7, p. 27). Rejections from this cause were so insignificant that the disease is not mentioned in discussing or listing causes for rejection in any Medical Statistics Bulletin of the Selective Service System.

B. With rare exceptions this disease does not attack a previously healthy heart. In a recent survey[21] 82 percent of the cases had been engrafted upon rheumatic heart disease, 14 percent upon congenital heart disease.

C. Even if we could cure 100 percent of the cases of bacterial endocarditis this would not change the rejection figures to the slightest degree, since the underlying heart disease, either rheumatic fever or congenital heart disease, would still remain and constitute cause for rejection.

2. Congenital heart disease

A. Dr. Connor correctly cites the success of surgery in correcting patent ductus arteriosus and coarctation of the aorta (723). He wisely refrains from listing any other lesions which might be cured or corrected by surgery.

B. In the hands of the few existing surgeons who are experienced in this field the mortality from surgery on the ductus arteriosus should be less than 5 percent.

C. However, in only one-third of the cases is the patent ductus arteriosus a single, uncomplicated lesion. In two-thirds of the cases it is merely one of a series of cardiovascular defects in the same patient[22] the associated lesions being, in order of frequency: transposition of the great vessels, atresia of the pulmonary artery, coarctation of the aorta, stenosis of the pulmonary artery, and tricuspid atresia.

D. These lesions which are associated with patent ductus arteriosus in about two-thirds of the cases are themselves serious cardiovascular abnormalities and would be cause for rejection.

E. With reference to coarctation of the aorta, associated abnormalities are present in somewhat less than half of all cases.

F. Surgical treatment of this condition is so recent that a very few cases comprise the entire body of data. One pioneer in this field, has just recently[23] reported a total of eight cases, with five good results and two deaths, i. e., a mortality of 25 percent.

G. The time to operate for this condition is during early childhood before the primary lesion has led to serious secondary changes, such as hypertension, which is itself a cause for rejection.

H. Granting that our surgeons are making amazing progress, we cannot consider as a factor in the rejection rates of World War II those surgical procedures which are only in an early stage of development or those which are to become available by future research. The medical profession cannot make the benefits of surgery felt retroactively.

I. Congenital heart disease occurred so infrequently in the men before the induction boards that nowhere is it listed separately as a cause for rejection. It has been estimated that all congenital heart lesions represent about 1.5 percent of all organic heart lesions,[23] but would represent a much smaller proportion of all cardiovascular lesions listed by selective service. Heart disease alone, accounted for about 5.3 percent of all rejections. If we assume that the proportion of congenital lesions was the same in these rejectees as it is in the general civilian population, congenital heart lesions altogether could not have been responsible for more than 0.1 percent of all rejections. From the arguments in the preceding sections, it seems rather obvious that medical care could not have altered more than an insignificantly small part of the 0.1 percent of the estimated rejections for congenital heart disease.

3. Effort syndrome

At this point Dr. Connor is indulging in pure speculation. The overwhelming majority of rejections for cardiovascular defects were for rheumatic heart disease, valvular heart disease, and arterial hypertension. Of the remainder, it is impossible to tell how many could possibly be related to effort syndrome on the basis of factual data available from Selective Service statistics. It is more likely that the group of men classed as "effort syndrome" by Dr. Connor were rejected as psychoneurotics.

4. Hyperthyroidism

I agree with Dr. Connor that by and large heart disease due to hyperthyroidism can be prevented. But here again, heart disease due to hyperthyroidism was of no practical significance in the population coming before the draft boards. More to the point, irrespective of the condition of the heart, hyperthyroidism per se is cause for rejection.[24]

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[21] Oglesby, Bland, and White, New England Journal of Medicine, 237 : 349, 1947.

[22] Heart Disease, Paul Dudley White, Macmillan, 1947, p. 311; see also table 4, opposite p. 267.

[23] White, Paul Dudley, Heart Disease, Macmillan, 1947, p. 260, table 3.

5. Rheumatic fever

Here Dr. Connor approaches something of practical significance. He agrees with me that it is impossible to prevent the initial attacks of rheumatic fever, and that rheumatic heart often occurs with the first attack. Dr. Connor then states (p. 723) that repeated attacks of rheumatic fever can be prevented by prophylactic therapy with sulfonamides or penicillin. The prophylactic use of such preparations was suggested only in most recent years. The status of such therapy is still far from clear. There are some authorities who deny that the prophylactic use of sulfonamides is of any value in rheumatic fever. For example, Dr. May Wilson in a conference conducted at St. Francis Sanatorium for Cardiac Children, Roslyn, Long Island, N. Y.,[25] stated, "I would not have given it (sulfonamide) in the first place. Until it can be definitely shown that prophylactic chemotherapy prevents recurrence, it is inadvisable to use a drug which may in some instances have deleterious effects."[26] Just a few months ago at public meeting at the Mount Alto Veterans' Hospital, Dr. Arnold Rich, of Johns Hopkins Medical School, said precisely the same thing in the presence of over 100 Washington physicians.

If the evidence for the prophylactic value of sulfonamides is, to say the least, controversial, the evidence to support Dr. Connor's statement regarding penicillin is nonexistent. I should like to challenge Dr. Connor to produce one scrap of reliable evidence that demonstrates the value of penicillin in preventing recurrent attacks of rheumatic fever.

Most important for our consideration is the fact that here also we are talking about therapeutic methods, of undemonstrated value, which were not in existence when the rejectees of World War II contracted rheumatic fever and were developing their rheumatic heart disease. Neither the sulfonamides nor penicillin are effective retroactively.

6. Syphilitic cardiovascular disease

Dr. Connor is unquestionably correct in his statement that almost all cardiovascular syphilis can be prevented by early medical treatment. We have already discussed the necessity of having the patient submit to this treatment, and the difficulties involved in bringing the patient to the doctor.

Actually rejections for cardiovascular syphilis amounted to only 0.2 percent of all rejections for syphilis,[27] and since syphilis accounted for about 9 percent of all rejections,[28] cardiovascular syphilis was responsible for about 0.02 percent of rejections.

7 and 8

Dr. Connor admits that nothing could have been done about either hypertension, which was responsible for about 37 percent of cardiovascular rejections, or arteriosclerosis, which was insignificant.

In brief, Dr. Connor has not submitted any evidence whatsoever to alter the estimates submitted with my original testimony.

REJECTION AMONG NEGROES AND THE POPULATION OF SOUTHERN STATES

(P. 697)

It was, indeed, my intention to show that the Selective Service recorded fewer curable defects among the Negroes than it did among the white rgistrants (p. 662, table 7, and last two paragraphs of text). Contrary to the statement of the FSA, this matter is not determined by definition. The full list cites 29 classes of defects (each of which may be further subdivided into several more specific types of defects). Of these 29 classes of defects, the Negro had higher rates in only 5; namely, educational and/or mental deficiency, gonorrhea, syphilis, cardiovascular, and "other medical." In the remaining 24 classes of defects the rates for white registrants was distinctly higher than for Negro registrants. Thus the difference between the two races was not merely a matter of definition.

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[24] MR 1–9, par. 83.

[25] American Journal of Medicine, vol. 2, 190, 1947.

[26] Ibid., pp. 194 and 196.

[27] Medical Statistics Bulletin No. 3, table 5, p. 121.

[28] Ibid., p. 19, table 5.

But the members of the FSA criticize the data cited from Medical Statistics Bulletin No. 3. They claim that my conclusions based on an analysis of table 6 are "untenable" (p. 697; par. 6). Inasmuch as no specific conclusions were drawn from table 6, I am not sure which conclusions the FSA regards as untenable. On page 698 (par. 5), however, the FSA makes a perfectly legitimate point regarding the limitations of the data I had submitted in table 7 (p. 662). They are quite correct in stating that there was some selection in the Negro registrants reaching the induction station for examination inasmuch as about twice as many Negroes were rejected by the local board in a "screening" examination. Presumably, for those Negroes rejected after such screening examination (e. g., for mental deficiency or for syphilis) only one defect was recorded, although some of these rejected Negroes might have had more than one defect.

Although I am confident that an impartial appraisal of the facts would indicate that the FSA has exaggerated the importance of this factor, I shall not contest the point. I do not contest it simply because we have other Selective Service data which are free from this objection. For the period covered by Medical Statistics Bulletin No. 2, the local board conducted detailed examinations on every registrant and recorded every defect. For the period covered by Bulletin No. 4, the local board did not perform screening examinations. Almost all registrants appeared at the induction station for a complete examination. It is significant that the data on total defects listed in Bulletins Nos. 2 and 4 are practically the same as those from Bulletin No. 3 which I had listed in my table 7.

In Bulletin No. 2 the total number of defects recorded per thousand men [29] were 1,595 and 1,494 for white and colored men, respectively.[30] Out of 28 separate categories of defects the Negro had higher rates than the white registrant in 6, i. e., syphilis, gonorrhea, genitalia, educational and/or mental deficiency, feet, and mouth, and gums. In six categories the rates were about equal, and in 16 categories the white registrants had significantly higher defect rates. It is obvious from the citations on page 698, paragraph 6, that the members of the FSA were cognizant of these facts. They did not bring them to the attention of this committee.

Similarly in the period covered by Bulletin No. 4,[31] out of 31 classes of defects listed the Negro had higher rates in 7; namely, syphilis, gonorrhea, failure to meet minimum intelligence standards, mental deficiency, feet, cardiovascular, and hernia. In five categories the rates were about equal. In the remaining 19 categories the rates for white registrants were significantly higher than for Negroes.

Thus eliminating the factor about which the FSA protested (p. 698, pars. 5 and 6) the picture presented by the Selective Service statistics is quite the same as I described to this committee in my original testimony. The essential truth is that for the great majority of all classes of defects the number of defects per thousand was significantly lower in the Negro.

Before discussing in any detail the significance of these data on the Negro I should like to call attention to one statement made by FSA on page 699 (par. 3), to the effect that rural rejection rates were higher than urban. Such statements which have been made frequently in the past are contrary to fact. From unpublished data of the Selective Service,[32] I present at this point a table which is numbered table 55 in a forthcoming publication. This publication will summarize the data for years 1941 to 1944, inclusive. You will note that table 55 gives acceptance rates rather than rejection rates. You will note that for white men a greater percentage were accepted from rural areas than from urban areas. For the colored man the rural and urban acceptance rates were about the same.

THE SIGNIFICANCE OF RECORDED DEFECTS IN SELECTIVE-SERVICE DATA

At no time have I ever stated or intimated that the Negro was "healthier" than the white man. The FSA statement to the contrary is false (p. 687, par. 4). I am quite certain that the health status of the Negro in this country is definitely inferior to that of the white man. I believe it can be shown that the quality of medical care received by the Negro is inferior to that received by the white man. If I am correct in these views then there is a complete lack of agreement between the actual health status of the Negro and his relative position in the recorded defects of the Selective Service System statistics. Indeed I used this very discrepancy to illustrate the fallacy of using the selective-service data either as a guide to the health of our Nation, or to the volume or quality of medical care being given to any one group. This point was made briefly but tersely and emphatically in the summary of my original testimony, section 9, under the heading "Summary of discussion of selective-service data."

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[29] In Bulletin No. 2 there was no limit on the total number of defects which could be recorded for each man. In Bulletins Nos. 3 and 4 no more than 3 defects could be recorded for each man.

[30] Table 7, p. 37; also pp. 24 to 36.

[31] Table 11, p. 21.

[32] Data examined at headquarters of Selective Service by the kind permission of officers of the Selective Service System.

Why can't we put the selective-service data to such use? In the first place a great many of the defects discovered and listed have very little significance in an evaluation of "health." I have repeatedly given examples of these and so have the official publications of the Selective Service System. Over one-half the defects listed are structural abnormalities rather than diseases. Of the remainder a significant number are related to education rather than to medicine or health. Of the structural abnormalities it is ironical that many are the direct result of medical treatment rather than the lack of it. For example, we may cite amputations, surgical perforations of the middle ear for the treatment of infections, purposeful ankylosis of joints in orthopedic surgery, and therapeutic spinal fusions. The very existence of some defects is evidence of our good "health" rather than the reverse. The fact that diabetics can live long enough to be registered by the draft boards and be recorded as "defects" is due to the wonders of our medical care and only by the grace of Best, Banting, and Collip. Every child with rheumatic fever carried into adult life by skillful medical care will live to be a rejectee. Every invalided infant who survives the tetralogy of Fallot, only because of the brilliant surgery of Blalock, will increase the number of "defects." Is a corpse healthier than a rejectee with diabetes?

In order to evaluate the health of a community one must consider, among other things, the crude death rate, the death rates for specific diseases, the age composition of the entire population, the morbidity rates for the various diseases and for childbirth, the birth rate, and the life expectancy. Even when we have carefully and satisfactorily evaluated the health status of one segment of our population we cannot draw any inferences regarding medical care or the volume of medical services without allowing for many other factors. Medical care is but one of many factors which determine the "health" of a community. I gave some evidence of these other factors in my original testimony by reference to the work of Dr. Hyde. I should now, in closing, give a few more illustrative examples. In the Philippines and in China our troops had just as many doctors and just as good medical care as the troops any place else. Nevertheless, at a time when there was no epidemic of poliomyelitis in the native children or the native adults our soldiers were coming down with this dread disease by the dozens. Was this because the medical service available to our soldiers was inferior to that of the native population? The official explanation is something else. It is believed that while our soldiers had built up considerable group immunity to our own, domestic strains of polio, they had built up no immunity to the foreign strains because of lack of repeated exposure during childhood. Hence the strain of relatively low virulence, which did not bother the native population, played havoc with our men. This, if true, illustrates the importance of the relationship of the host to the organism and the factor of acquired group immunity. Another factor is purely geographic. It is well illustrated by the distribution of rheumatic heart disease in this country. The incidence is very low in Louisiana and high in New England. Indeed, the child of a poor Negro farmer in Louisiana has less chance of getting rheumatic heart disease than the son of a wealthy family in Boston. There are many other examples, but these will suffice. In plain words, one cannot say that the medical care in Wales is poorer than that in New Zealand merely on the basis of certain differentials in death rates and morbidity rates. These rates will reflect medical care only if other equally important factors are the same.

THE DISTRIBUTION OF MEDICAL FACILITIES

I admit that my estimates of the number of physicians needed were based on the Lee-Jones figures for diagnosis and treatment only. To this the FSA criticism of my statement (p. 699, par. 5) is justified. However, it should be emphasized that no one is in a position to state at this time precisely how many physicians are needed per thousand population. I should like to call to the attention of this committee that during the war years, when the number of doctors available to the civilian population was reduced by at least one-third, many of the reliable indices of our national health showed marked improvement. For example, from 1938 to 1945 the infant mortality in the United States dropped from 51 to 38.3 per thousand live births. During this same period of time the maternal mortality dropped from 4.4 to 2.1 per thousand live births.[33]

The FSA now admits that the county is a poor unit for measuring the adequacy of medical facilities (p. 700, par. 1). They even cite an opinion in a Public Health Service report 4 years ago that serious errors are likely to be encountered by the use of such small geographic units. The FSA had not called the attention of this committee to these facts.

The FSA contends that the statement of Falk, Klem, and Sinai (p. 701, first sentence) about the accessibility of hospitals in rural areas was true only of the population sample surveyed. This was obvious and understood. But since the authors drew from the survey on this population sample far-reaching and general conclusions about the frequency of illness and the distribution of medical facilities for the Nation as a whole, it was natural to assume that the authors considered this population sample a representative one. Since one of the authors is now a member of the FSA, we must accept the opinion of this Federal Agency that the population sample studied by Falk, Klem, and Sinai was not truly representative.

Regardless of these considerations, I have never passed any definite judgment on the need for hospitals in rural areas. My only contention was that we cannot properly ascribe the lower volume of hospital care in rural areas to a lack of hospital beds when the people in rural areas are not making full use of the hospital facilities already available (p. 664, last paragraph, also original manuscript, summary, p. 2, sec. 4). Personally, I cannot see the wisdom of building more hospitals in such areas until we can ascertain why the people are not using the hospital facilities already at their command.

With reference to physicians' services I am glad to accept table H of the rebuttal (p. 702). This reports that per case of illness the rural number of physicians' calls were only about 80 percent of the number for small cities, and only 70 percent of the number in the largest cities. The important question for us to determine is why this should be so. The FSA does not contest the accuracy the reproduction of data in my original discussion of rural medical services. They admit (p. 703) that diphtheria immunizations were more frequent in the rural areas and that physical examinations were more frequent in towns under 5,000 population than in the cities. Their only comment on this point is that in the table I originally presented these items are combined. (See table 12, "Health examinations and immunizations," p. 665.)

The FSA infers that I have come to some very definite conclusions regarding the distribution of medical facilities in this country, and that I deny the existence of any serious maldistribution of these facilities. Actually, I have refrained from drawing any definite conclusions on this subject in the absence of what I consider satisfactory data. I do believe that the presentations of the FSA have grossly exaggerated the faults of our distribution of medical services. One reason for this exaggeration is the persistent use of the county as a unit—a practice which the FSA now admits is a poor one. I also believe that they have not given sufficient recognition to the extreme mobility of our population as contrasted with the mobility of rural peoples in other nations—a mobility made possible by our highway systems and the widely distributed ownership of automobiles made possible by the efficiency of private enterprise in this country. These are but a few of the factors which have not received sufficient attention in these discussions.

THE ECONOMIC BARRIER TO ADEQUATE MEDICAL CARE

(P. 703)

Here again the FSA does not challenge the verity of the factual material submitted in my original testimony. They do claim, however (p. 703, last paragraph) that I have overlooked the relation of economic status to receipt of care, the necessity for periodic health examinations (p. 704, par. 2) and the presence of actual illness in some patients who are unaware of it and therefore do not report it (p. 704, par. 5). That I have not overlooked these factors can be seen by reference to tables 10, 11, 12, 14, 17, and 18 in my original testimony, and to the text accompanying these tables, particularly the first paragraph on page 667.

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[33] United States Summary of Vital Statistics, State Summaries, Special Reports, vol. 26, No. 1. April 4, 1947, p. 7, table A.

The members of the FSA cite (p. 704, par. 4) conducted by the National Physicians' Committee which reported that about 30 percent of the persons interviewed had (they said) postponed going to a doctor because of cost. The decision to spend certain parts of the family income on medical care rather than on certain optional expenditures is colored by the spending habits of the individuals and their particular evaluation of the importance of medical care. I have discussed these aspects in detail on pages 674 to 677.

I am glad to have table K submitted in the rebuttal on page 705. To be sure medical attendance increases somewhat with increasing income. But please note that in nonrelief groups a rise of over 500 percent in income is accompanied by an increase of only 18 percent in the percent of illness receiving doctor's care, and by an increase of only 16 percent in the number of doctor's calls per disabling case. These figures are no different from the data I had presented to this committee earlier. To appreciate these figures, however, one should keep in mind that the number of aged persons is greater in the higher income groups than in the lower income groups, so that each illness in the higher income groups is apt to be more serious because of the increased frequency of heart disease, hypertension, diabetes, and cancer in the older ages (p. 667, par. 2) ; p. 667, last paragraph, last sentence).

THE INCIDENCE OF ILLNESS

(P. 706)

The FSA statement that the CCMC found illness to occur with much the same frequency among rich and poor is not substantiated by the original data. I have reproduced these data in table 13. The FSA has not and cannot challenge the accuracy of this table. These data show that the incidence of illness in the highest income group was 40 percent greater than in the lowest income group. The FSA explanation of these figures on the basis of a different income distribution for this sample is not acceptable. The difference is not merely between the extremes. Between the lowest income group and the highest income group there is a regular, steplike increase in illness with each increment of income.

We cannot measure illness, as they attempt to (p. 706, par. 2) by totaling the number of days of reported disability. Too many factors enter into a person's desire to return to work. The will to work is not the same in everyone.

The insertion of table M on page 707 is most welcome. I had already cited these data on page 668 without putting them into tabular form. We may note from this table that the reported frequency of illness of all types is much higher in persons on the relief rolls. But note, when we consider self-supporting persons with family incomes less than $1,000 the frequency of illness is much lower than in relief families and not so much different from the frequencies of the higher income groups. Once the level of family income reaches $1,000 per year the frequency of illness shows very little change up to the highest income. For acute illnesses this change is less than 10 percent. For chronic illness an increase of income from $1,000 per year to $5,000 per year and over is associated with no change whatsoever in frequency; i. e., there is no correlation between income and illness.

The FSA objects to my appraisal of the technical qualifications of the persons who conducted the National Health Survey. They do not deny (p. 708) that these workers were taken from the relief rolls, but they attempt to establish the fact that these workers were really trained and adequate to the task. I admit that "preference was given to white-collar workers," etc. But I insist that white-collar workers with no previous experience in the technical aspects of medicine cannot be adequately trained for such survey by systematic training of "10 days or longer." [34] The efforts might have been sincere, but the results clearly show the inadequacies. Of a total of about 35,000,000 cases of chronic disease listed in this survey almost 7,000,000 were labeled "rheumatism." In other words 20 percent of the entire compilation is placed under a label which is meaningless from a medical standpoint. According to Bulletin No. 9 of the National Health Survey (p. 10) rheumatism is defined as arthritis, gout, neuralgia, neuritis, lumbago, acute rheumatic fever, stiff neck, and other muscular pains. In other words any kind of ache or pain occurring in or referred to the extremities, bones, or joints was labeled rheumatism. We may also note that menopause is[35] included among the diseases counted as chronic diseases of the female organs.

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[34] National Health Survey, Reprint No. 2098, p. 7 (2), by George St. J. Perrott, Clark Tibbitts, and Rollo H. Britten.

The FSA is correct in pointing out the high degree of confirmation of the survey diagnoses (p. 708, par. 4) in those cases in which the physicians replied to the questionnaire. They do not deny, however, that only 26 percent of all tabulated illnesses were so confirmed. It is possible that a correspondingly high degree of agreement between the survey diagnosis and the physician's diagnosis would have been attained if all questionnaires had been returned by the physicians. On the other hand, it is equally possible that physicians who agreed with the survey diagnosis were more inclined to answer the question. Simple confirmation is easy, and offends no one. Much more is involved in denying the statement of a patient. More effort is involved and many men might be reluctant to do so.

The FSA brief lecture on statistical methods (bottom of p. 708) is appreciated, but superfluous. I specifically acknowledge (p. 668, par. 4) that not only are age adjustments permissible, but necessary for specific purposes. For the purposes of this committee, however, and for other lay persons not especially trained in statistical studies on health matters, it is of prime importance that the use of such adjustments should be prominently noted in the reports, and that the nature and purposes of all adjustments should be clearly explained. This is particularly true when we are trying to determine the actual health needs of various segments of our population, and medical services needed by those segments of our population. These needs are best measured by crude, unadjusted rates. They are determined by the actual composition of the population segments and not by the composition which would exist if these segments were like every other segment. For example, in the population surveyed by CCMC persons over 45 years of age comprised 12 to 15 percent of the population with incomes less than $3,000. In the $5,000 to $10,000 income class, persons over 45 amounted to 23 percent of the population. In the class with incomes over $10,000 they amounted to about 30 percent of the population. In the National Health Survey (cf. p. 667) this age group accounted for 20 percent of persons on relief, but 30 percent of persons with incomes of $5,000 or over. In other words, the age distribution of the CCMC population sample and of the National Health Survey sample were not the same. Which, if either, is correct? What is the proper age distribution by income groups for our entire country. This is not merely a question of economics. It is of utmost importance in calculating the medical needs and the distribution of medical services because of the very great influence of age on disease rates. This is especially true of our most serious diseases such as heart disease, nephritis, hypertension, and cancer.

THE VOLUME AND DISTRIBUTION OF MEDICAL SERVICES

(p. 709)

The insertion of table Q by the FSA at this point is not unwelcome, but it adds nothing. This table is simply a more complicated version of my table 17, page 671. Table R is quite a welcome addition. It shows, as I have shown in my original testimony, a complete lack of correlation between volume of hospital care and family income.

Equally welcome is table S on page 711. If we inspect the first column of this table, we note that persons with incomes less than $1,200 received more examinations than any other higher-income group until the level of $5,000 is reached. Even excluding infant care, there was no great difference in the volume of services until the level of $3,000 is reached. Although the matter of free school examinations is quite properly brought into the discussion (p. 711, last paragraph), this factor should not have influenced the volume of services in the 25 to 44 age group. But in this age group also the correlation between services and income is a poor one. I should like to acknowledge that this table shows a pronounced and regular relation between income and volume of services for the older persons surveyed (those over 45 years of age). I regard this as a serious matter which should be further investigated.

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[35] National Health Survey, Bulletin No. 6, p. 15 (f), U. S. Public Health Service, Washington. 1938 (revised, 1939).

Table U, presented on page 713, shows the frequency of surgical operations and the influence of income thereon. Taking the figures in this table at face value (and ignoring the question of the size of samples and sampling error, etc.) let us inspect the data on essential operations as opposed to what might be termed optional procedures. The latter do show a relation to income. But, looking at appendectomies and other abdominal operations, we find a very poor correlation with income. The data on bonesetting might place the low-income groups in an unjustifiably favorable light, since their occupational hazards might entail a greater risk of fracture. Table V, on page 714, considers surgical services in relation to need (or diagnosis rather), but does not list bonesetting specifically. However, for accidents in general the surgical services rendered show no correlation with income. For appendectomies this table shows some correlation between number of operations and income, except in the older-age groups, where there is no correlation. Do these data mean that cases of acute appendicitis in the lower-income groups are actually being neglected, or do these data reflect a greater number of optional appendectomies in the higher-income groups? This question cannot be answered by inspection of the data presented.

(Whereupon, at 5 p. m., the subcommittee adjourned until 10 a. m., Friday, January 30, 1948.)

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